

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 24038

00-17192

1- FOR STATE REGISTRAR		2a. DECEASED NAME (TYPE OR PRINT)		3. SEX		4. RACE		5. DATE OF BIRTH (MONTH DAY YEAR)		6. AGE (IN YEARS LAST BIRTHDAY)		7. DATE KNOWN OF DEATH (ESTI. MONTH DAY YEAR)		8. HOUR	
		CLARICE JEWEL ANDREWS		female		white		May 12, 1927		59 YRS.		8/30/86		5:06 A.M.	
		7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH							
		North Carolina		U.S.A.				WASHINGTON C. MD.							
		10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY							
		Hagerstown		Washington County Hospital											
		13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS					
		North Carolina		Orange		Carrboro				111 Pine Street					
		14. FATHER'S NAME (FIRST MIDDLE LAST)		15. MOTHER'S MAIDEN NAME (FIRST MIDDLE LAST)											
		LeRoy Crofts		Berchie Briles											
		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT		ADDRESS							
		no													
		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)		PART 1 DEATH WAS CAUSED BY:		IMMEDIATE CAUSE (a)		DUE TO, OR AS A CONSEQUENCE OF		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH					
		8129				MULTIPLE TRAUMATIC INJURIES (INTERNAL)		# N-869		2 HOURS					
		Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost.				(b)		DUE TO, OR AS A CONSEQUENCE OF							
						(c)		MOTOR VEHICLE/NOT. VEHIC. COLLISION #E-812							
		PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a):													
		19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>									
		21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)									
		21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE									
		22a. I certify that I took charge of the remains described above, held on death resulted from:		Noturol causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>		Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion									
		ACTUAL SIGNATURE		TITLE (SPECIFY)		DATE SIGNED									
		George Milic		M.D. DEPUTY MEDICAL EXAMINER		8/30/86									
		EXAMINER'S NAME (TYPE OR PRINT)		ADDRESS											
		GEORGE MILIC, M.D.		40 MANOR DRIVE #103 HAGERSTOWN, MD.											
		23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION CITY OR TOWN COUNTY STATE							
		burial		Sept. 2, 1986		Westwood Cemetery		Carrboro, Orange, North Carolina							
		24. FUNERAL DIRECTOR NAME		ADDRESS		25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE							
		MINNICH FUNERAL HOME		415 East Wilson Blvd., Hagerstown, Maryland		SEP 5 1986		John Davidson							

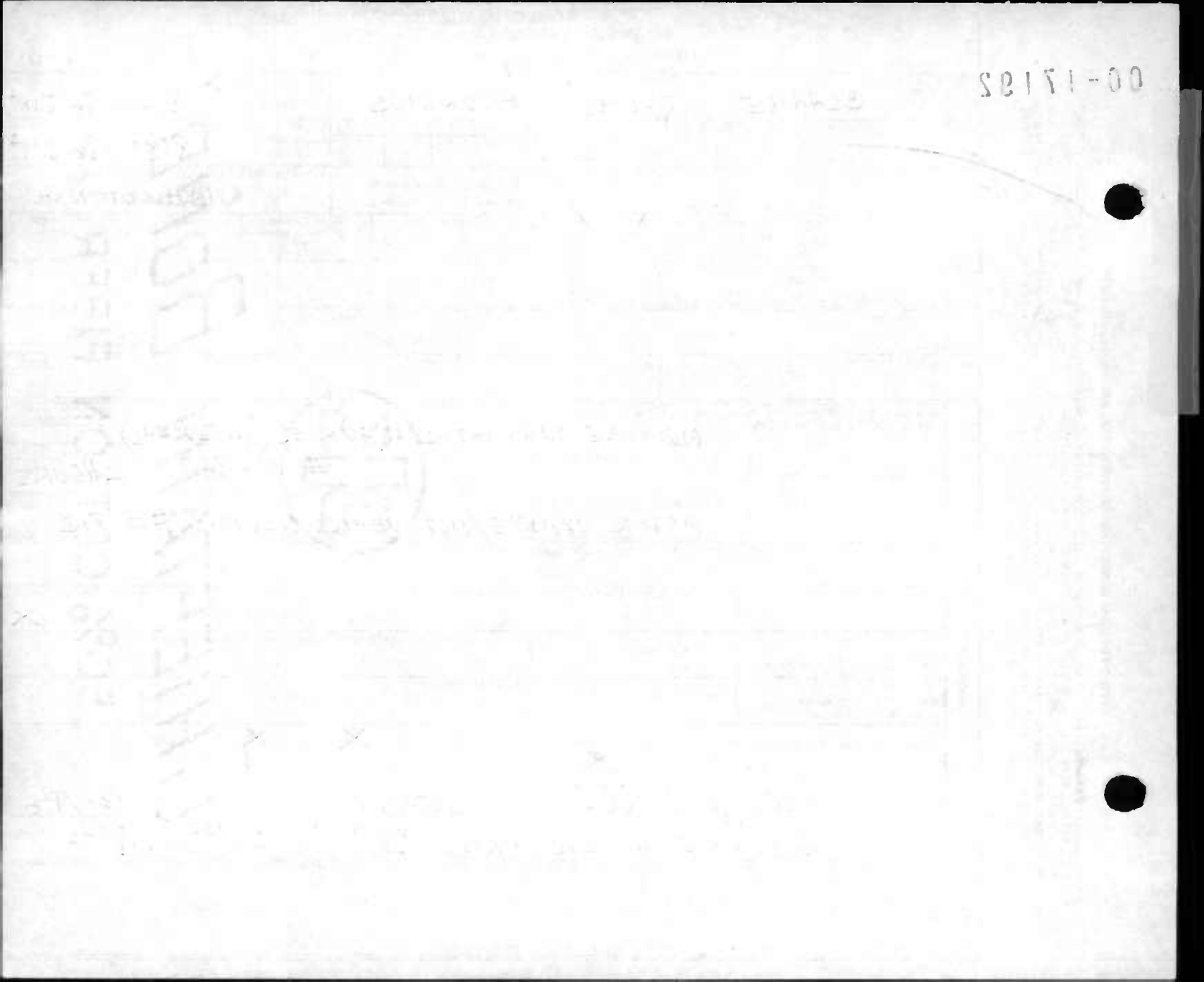
DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD, 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER, ALONG WITH FORM 1001. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH. WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

MEDICAL CERTIFICATION

DHMH 17 (VR A15 ME (5))

00-15185



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP

DHMH - 16 60M 7/84  
(VIA 15, 4)

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 6 2 4 0 3 9

REG. NO.

1- FOR  
STATE  
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST merle C. Baker			2a. DATE OF DEATH MONTH DAY YEAR 8 27 86			2b. HOUR 9:35 PM			
3. SEX male		4. RACE Caucasian		5. DATE OF BIRTH MONTH DAY YEAR 10 27 20		6. AGE (IN YEARS LAST BIRTHDAY) 65 YRS.		7. IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Washington MD.			
10. CITY OR TOWN OF DEATH Hagerstown		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Washington County Hospital				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Machine Operator		12b. KIND OF BUSINESS OR INDUSTRY Machine Co.	
13a. STATE md.		13b. COUNTY Washington		13c. CITY OR TOWN Smithsburg		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 21783 A E. Under St., Box 81	
14. FATHER'S NAME FIRST MIDDLE LAST Calvin L. Baker		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Rose M. Hartle		16. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) No					
16a. SOCIAL SECURITY NO. 214-14-6844		17. INFORMANT Mrs. Nancy J. O'Sullivan							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiogenic Shock</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Acute Myocardial Infarction</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>Arteriosclerotic Heart Disease</u>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1 hr 1 hr ?							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1B, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from 8-27 19 86, to 8-27 19 86, that (I) (we) last saw the deceased alive on 8-27 19 86, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE John H. Hornbaker Jr.		DEGREE		22c. DATE SIGNED 8-28-86					
22d. PHYSICIAN'S NAME (TYPE OR PRINT) John H. Hornbaker Jr.		22e. ADDRESS 645 E. First St., Hagerstown, Md. 21740							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 8/31/1986		23c. NAME OF CEMETERY OR CREMATORY Leitersburg Lutheran Cem.		23d. LOCATION CITY OR TOWN COUNTY STATE Leitersburg Washington Md.			
24. FUNERAL DIRECTOR NAME [Signature]		ADDRESS 50 S. Broad St. Waynesboro, PA		25a. DATE REC'D. BY REGISTRAR SEP 03 1986		25b. REGISTRAR'S SIGNATURE [Signature]			

X

U.S.A.

Machine Operator No. 10.

1978

X

Hamilton

North

West

East

South

2000 North Ave., N.Y.

Mr. Henry J. Hamilton, 210-11-5511

Mr. J. J. Hamilton, 210-11-5511

John J. Hamilton

United States Department of Justice

2000 North Ave., N.Y.

Hamilton, N.Y.

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8624040

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST: Robert MIDDLE: Clarence LAST: Baker		2a. DATE OF DEATH MONTH: 8 DAY: 5 YEAR: 86		2b. HOUR 5:15 P. M.	
3. SEX Male		4. RACE Cauc		5. DATE OF BIRTH MONTH: 9 DAY: 3 YEAR: 14	
6. AGE (IN YEARS LAST BIRTHDAY) 71 YRS.		7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Hagerstown, Md		7b. CITIZEN OF WHAT COUNTRY? USA	
8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Washington MD.			
10. CITY OR TOWN OF DEATH Hagerstown		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Washington County Hospital		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)	
12b. KIND OF BUSINESS OR INDUSTRY		13a. STREET ADDRESS / ZIP CODE 531 Jefferson St. 21740			
14. FATHER'S NAME FIRST: Edward MIDDLE: LAST: Baker		15. MOTHER'S MAIDEN NAME FIRST: Sarah MIDDLE: LAST: Wiley			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) no		16b. SOCIAL SECURITY NO. 220-09-7871		17. INFORMANT ADDRESS Clara B. Baker, Hagerstown, Md.	
18. CAUSE OF DEATH (Enter only one cause per line (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Respiratory Failure</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Chronic Obstructive Pulmonary Disease</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>None</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: (a) <u>Stroke with Dehydration</u>					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			
21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from <u>8/5/86</u> to <u>8/5/86</u> , that (I) (we) last saw the deceased alive on <u>8/5/86</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE <u>Gloria F. Pura</u>		DEGREE		22c. DATE SIGNED 8/6/86	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) GLORIA F. PURA		22e. ADDRESS 339 E. ANTIETAM ST. HAGERSTOWN			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) burial		23b. DATE Aug. 8, 1986		23c. NAME OF CEMETERY OR CREMATORY Leitersburg Cemetery	
23d. LOCATION CITY OR TOWN COUNTY STATE Leitersburg, Wash., Maryland		24. FUNERAL DIRECTOR MINNICH FUNERAL HOME NAME: 415 E. Wilson Blvd., Hagerstown, Md. 21740 ADDRESS:			
25a. DATE REC'D. BY REGISTRAR AUG 8 1986		25b. REGISTRAR'S SIGNATURE <u>Julia Davidson-Purdon</u>			

MEDICAL CERTIFICATION

99

BP

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 22 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

00-14800

1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner should be notified at once.

BP \_\_\_\_\_

DHMH - 16 60M 7/84  
(VRA 15, 4)STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

86 24041

REG. NO.

1 - FOR  
STATE  
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <b>ELENA V. BALUTEL</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>August 21 86</b>		2b. HOUR <b>2:27 P.M.</b>		
3. SEX <b>Female</b>		4. RACE <b>White</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>Sept. 14 1921</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>64</b> YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Rumania</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Washington</b> MD.	
10. CITY OR TOWN OF DEATH <b>Hagerstown</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Washington County Hospital</b>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Clerk</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>General Electric</b>	
13a. STATE <b>Maryland</b>		13b. COUNTY <b>Washington</b>		13c. CITY OR TOWN <b>Hagerstown</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
13e. STREET ADDRESS / ZIP CODE <b>30 Manor Drive Apt. 204 21740</b>		14. FATHER'S NAME FIRST MIDDLE LAST <b>Vasile Mihaescu</b>		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Elena Suslov</b>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>N/A</b>		16b. SOCIAL SECURITY NO. <b>128-40-4150</b>		17. INFORMANT <b>John Balutel-husband-(same as 13e)</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Squamous Cell Carcinoma of</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>Metastatic tumor with spread</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>May 85</b>						APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>3:00 a.m. 21 86</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE <b>late</b>			
22a. I certify that (I) (this hospital) attended the deceased from <b>3:00 a.m. 21 86</b> to <b>late</b> 9, that (I) (we) last saw the deceased alive on <b>21 Aug 19 86</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (If we died; did not) view the body after death.							
22b. SIGNATURE <b>Richard T. Binford, MD</b>				22c. ADDRESS <b>1135 Potomac Avenue, Hagerstown, Md. 21740</b>		22e. DATE SIGNED <b>8/21/86</b>	
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>8-23-1986</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Rock Creek Cemetery</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Washington, D.C.</b>	
24. FUNERAL DIRECTOR NAME <b>Hines/Rinaldi Funeral Home</b>				25a. DATE REC'D. BY REGISTRAR <b>AUG 25 1986</b>		25b. REGISTRAR'S SIGNATURE <b>John Anderson-Henderson</b>	





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

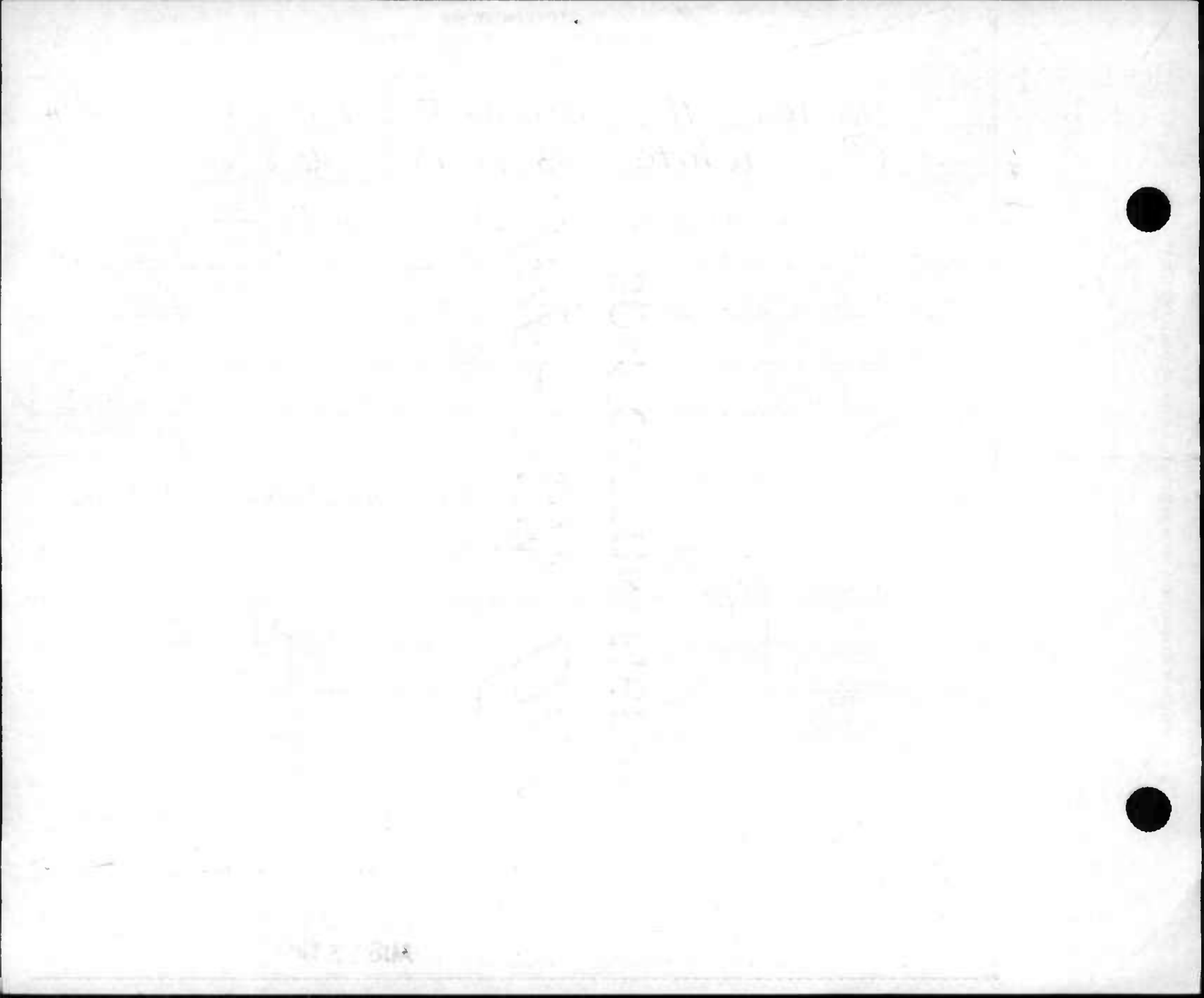
86 24042

1. FOR  
STATE  
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) <b>Charles Henry H. Barnhart</b>				2a. DATE OF DEATH MONTH DAY YEAR <b>8-10-86</b>		2b. HOUR <b>2:17 A.M.</b>	
3. SEX <b>male</b>		4. RACE <b>white</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>3 19 18</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>68</b> YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Maryland</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Washington</b> MD.	
10. CITY OR TOWN OF DEATH <b>Hagerstown</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Washington County Hospital</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>guard</b>	
12b. KIND OF BUSINESS OR INDUSTRY <b>state prison</b>							
13a. STATE <b>Maryland</b>		13b. COUNTY <b>Washington</b>		13c. CITY OR TOWN <b>Hagerstown</b>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
13e. STREET ADDRESS / ZIP CODE <b>Route 9, Box 106 21740</b>							
14. FATHER'S NAME FIRST MIDDLE LAST <b>Lester Barnhart</b>		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Alta Lumm</b>					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>Yes</b>		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) <b>W.W.II</b>		17. INFORMANT <b>Mrs. Sylvia Barnhart, Hagerstown, Maryland</b>		ADDRESS	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) _____ DUE TO, OR AS A CONSEQUENCE OF (b) <b>Acute pulmonary Edema</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>Acute M.I.</b>				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>1-2 hrs</b> <b>11</b>			
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a) <b>A SHD COPD</b>							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1B, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE <b>[Signature]</b>		DEGREE		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED <b>8-11-86</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>W.B. KANG, M.D.</b>		22e. ADDRESS <b>1933 Va. Ave., Hagerstown, Md. 21740</b>					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>burial</b>		23b. DATE <b>Aug. 12, 1986</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Rest Haven Cemetery</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Hagerstown, Wash., Maryland</b>	
24. FUNERAL DIRECTOR NAME ADDRESS <b>MINNICH FUNERAL HOME 415 E. Wilson Blvd., Hagerstown, Md. 21740</b>				25a. DATE REC'D. BY REGISTRAR (25b. REGISTRAR'S SIGNATURE) <b>AUG 13 1986</b>			

MEDICAL CERTIFICATION



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 4 may be retained by the hospital or attending physician.

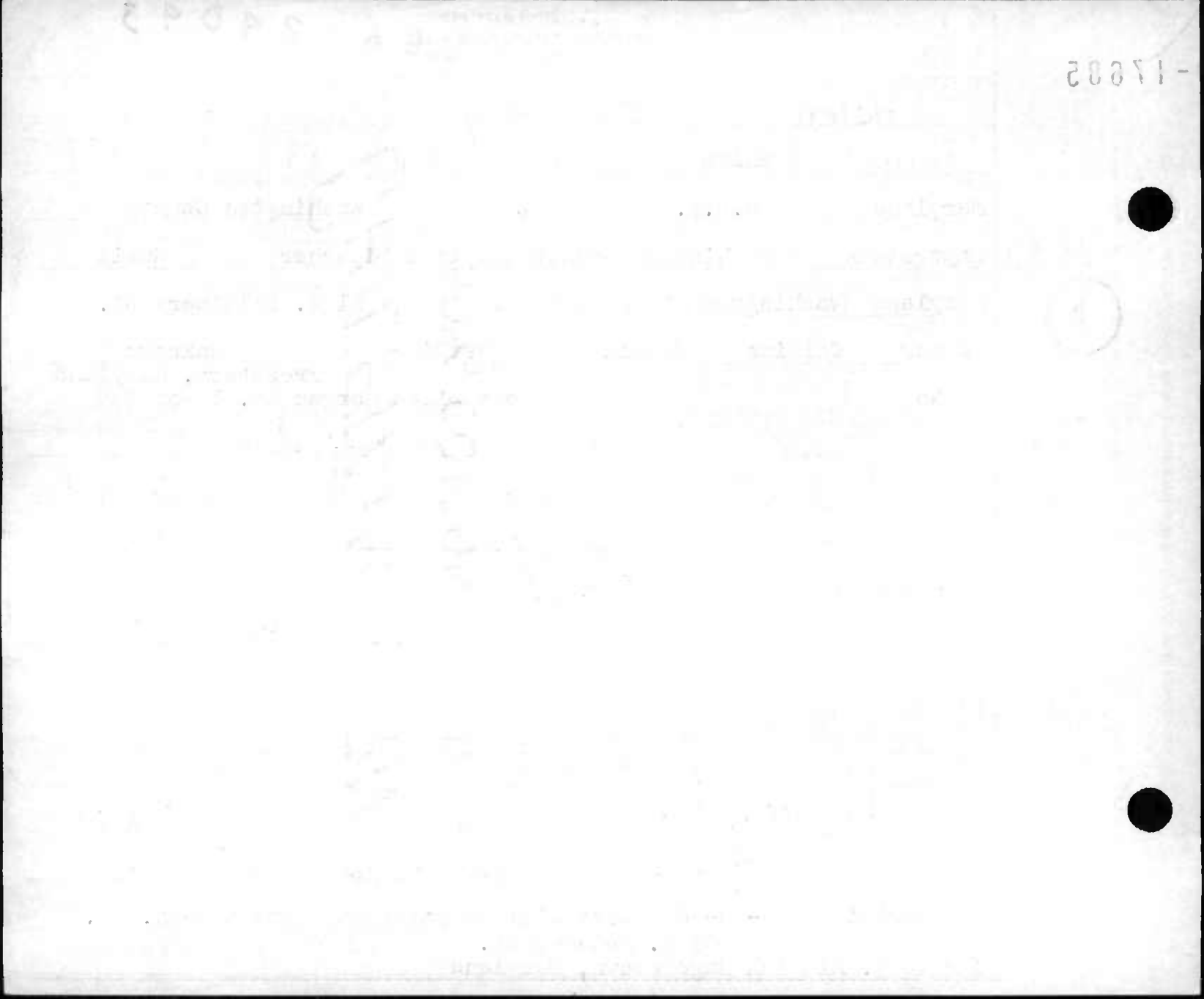
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical certificate must be notated as such.

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										REG. NO. 24043	
1. DECEASED NAME (TYPE OR PRINT) <b>Helen Beachley</b>						2a. DATE OF DEATH MONTH DAY YEAR <b>8 27 1986</b>		2b. HOUR <b>M</b>			
3. SEX <b>Female</b>		4. RACE <b>White</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>4 13 1897</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>89</b> YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Maryland</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Washington County</b> MD.					
10. CITY OR TOWN OF DEATH <b>Hagerstown</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Washington County Hospital</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Teacher</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>Music</b>			
13a. STATE <b>Maryland</b>		13b. COUNTY <b>Washington</b>		13c. CITY OR TOWN <b>Hagerstown</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE <b>11 W. Baltimore St. 21740</b>			
14. FATHER'S NAME FIRST MIDDLE LAST <b>James Collins Unseld</b>				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Nettie Unknown</b>							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>No</b>		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES)		17. INFORMANT <b>Rose Ellen Morgan Rt. 1 Box 245</b>							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Auto road failure</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Grave G5 Sepsis</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>CHF</b> Severid dysc 1 wk											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <b>Multiple myeloma, RT Breast ca. ASHD</b>											
19a. DATE OF OPERATION <b>2/29/86</b>		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE							
22a. I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) lost saw the deceased alive on _____, 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE <b>W. B. KANG, M.D.</b>				DEGREE		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED <b>8-28-86</b>			
22d. PHYSICIAN'S NAME (TYPE OR PRINT)				22e. ADDRESS <b>1933 Va Ave. Hagerstown, Md.</b>							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>8-30-86</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Rose Hill Cemetery</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Hagerstown Wash. Md.</b>					
24. FUNERAL DIRECTOR NAME <b>Gerald N. Minnich Hagerstown, Maryland</b>				305 N. Potomac St.		SEP 03 1986 JULIA BENDON-RODNEY					

BP \_\_\_\_\_



STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

24044

1- FOR  
STATE  
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT)			FIRST MIDDLE LAST			2a. DATE KNOWN OF DEATH			MONTH DAY YEAR			2b. HOUR		
Timothy Frederick Belew						8/ 9/ 19 86						M		
3. SEX	4. RACE	5. DATE OF BIRTH	6. AGE (IN YEARS)	IF UNDER 1 YR.	IF UNDER 24 HRS.	2c. DATE PRONOUNCED DEAD			MONTH DAY YEAR			2d. HOUR		
Male	White	March 8, 1966	20 YRS.	MONTHS	DAYS	8/ 9/ 19 86						A M		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)			7b. CITIZEN OF WHAT COUNTRY?			8. MARRIED			NEVER MARRIED			9. BALTIMORE CITY OR COUNTY OF DEATH		
Pennsylvania			U.S.A.			WIDOWED			DIVORCED			Washington County, MD.		
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS					
Hagerstown			Hagerstown Drive-In Theater			Laborer			Jobe Paving Co.					
13. RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)														
13a. STATE			13b. COUNTY			13c. CITY OR TOWN			13d. INSIDE CITY LIMITS?			13e. STREET ADDRESS		
Md.			Wash.			Smithsburg			YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			Rt. 3, Box 350 21783		
14. FATHER'S NAME						15. MOTHER'S MAIDEN NAME								
Claude Thomas Belew Jr.						Trudy D. Fuss								
16a. WAS DECEASED EVER IN U.S. ARMED FORCES?						16b. SOCIAL SECURITY NO.						17. INFORMANT ADDRESS		
no						219-86-4975						Mr. C. Thomas Belew, Smithsburg, Md.		

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART I DEATH WAS CAUSED BY:			
IMMEDIATE CAUSE (a) Multiple Gunshot Wounds			
DUE TO, OR AS A CONSEQUENCE OF			
Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.			
(b)			
DUE TO, OR AS A CONSEQUENCE OF			
(c)			

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a):

19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?		20. AUTOPSY?	
				YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)	
12:20AM 8/ 9/1986		subject shot			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION	
drive in		Hagerstown Drive-In Theater, Washington Co., Md.			

22a. I certify that I took charge of the remains described above, held on						Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion	
death resulted from:						Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input checked="" type="checkbox"/> Undetermined manner <input type="checkbox"/> .	
ACTUAL SIGNATURE						TITLE (SPECIFY)	
Gregory R. Kauffman, M.D.						Assistant MEDICAL EXAMINER	
EXAMINER'S NAME (TYPE OR PRINT)						DATE SIGNED	
111 Penn St.						8/9/86	

23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION	
Burial		Aug. 13, 1986		Green Hill Cemetery		Waynesboro Franklin, Pa.	
24. FUNERAL DIRECTOR NAME				25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE	
Davis Funeral Home, Smithsburg, Md., 21783				AUG 15 1986		John Davidson	

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH, IF ANY DELAY IS NECESSARY. PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18, GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM 10-3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT FORMAL. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

07/84  
25M

BP

DHMH - 17  
(VR A15 ME (5))

ORIGINAL FILED

[Faint, mostly illegible text covering the main body of the page, possibly a letter or report.]

Very truly yours,  
[Signature]

007-16073

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

24045

1. DECEASED NAME (TYPE OR PRINT) <b>Arlo</b> <b>Birdett</b> <b>Blosser</b>		2a. DATE OF DEATH MONTH DAY YEAR <b>8-13-86</b> <b>8-13-86</b>		2b. HOUR MIN. <b>7:00 P.</b>	
3. SEX <b>Male</b>	4. RACE <b>White</b>	5. DATE OF BIRTH MONTH DAY YEAR <b>Nov. 26, 1909</b>		6. AGE (IN YEARS LAST BIRTHDAY) YRS. <b>76</b>	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Indiana</b>	7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Washington</b> MD.	
10. CITY OR TOWN OF DEATH <b>Hagerstown</b>	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Washington Co. Hospital</b>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Manager</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>Store</b>
13a. STATE <b>Md.</b>		13b. COUNTY <b>Wash.</b>	13c. CITY OR TOWN <b>Hagerstown</b>	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	13e. STREET ADDRESS / ZIP CODE <b>2417 Pa. Ave., Apt. 2 21740</b>
14. FATHER'S NAME FIRST MIDDLE LAST <b>Warren - Blosser</b>		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Emma - Hoffer</b>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>no</b>		16b. SOCIAL SECURITY NO. <b>308-03-4156</b>		17. INFORMANT ADDRESS <b>Edith M. Blosser, Hagerstown, Md. 21740</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Respiratory failure</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>Heart due to obstructive Pulm &amp; renal</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO, OR AS A CONSEQUENCE OF (c)					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a.					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			
21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1B PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from <b>May 1</b> , 19 <b>82</b> , to <b>8-13-86</b> , 19 <b>86</b> , that (I) (we) last saw the deceased alive on <b>8-13-86</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE <b>E. R. Hurdzinski</b>		DEGREE <b>MD</b>		22c. DATE SIGNED <b>8-13-86</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>E. R. Hurdzinski</b>		22e. ADDRESS <b>282 Jordan Street, Arguing, Md.</b>			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Cremation</b>		23b. DATE <b>Aug. 14, 1986</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Smithsburg Crematory</b>	
23d. LOCATION CITY OR TOWN COUNTY STATE <b>Smithsburg, Wash., Md.</b>		25a. DATE REC'D. BY REGISTRAR <b>AUG 21 1986</b>			
24. FUNERAL DIRECTOR NAME <b>Davis</b>		25b. REGISTRAR'S SIGNATURE <b>Julia Davidson-Randall</b>			
24. FUNERAL HOME <b>Davis Funeral Home, Smithsburg, Md., 21783</b>					

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 2 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, Page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 3 should be filed with 42 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

BP





00-14643

1. FOR  
STATE  
REGISTERSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

6 6 24046

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST <u>Helen E</u> LAST <u>Bodkin</u>		2a. DATE OF DEATH MONTH <u>8</u> DAY <u>04</u> YEAR <u>86</u>		2b. HOUR <u>6:30</u> A.M.	
3. SEX <u>Female</u>		4. RACE <u>Can.</u>		5. DATE OF BIRTH MONTH <u>10</u> DAY <u>02</u> YEAR <u>17</u>	
6. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <u>umberland, Md.</u>		7b. CITIZEN OF WHAT COUNTRY? <u>USA</u>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
10. CITY OR TOWN OF DEATH <u>HAGERSTOWN, Md.</u>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <u>WASHINGTON County Hospital</u>		9. BALTIMORE CITY OR COUNTY OF DEATH <u>WASHINGTON COUNTY MD.</u>	
13a. STATE <u>Maryland</u>		13b. COUNTY <u>Washington</u>		13c. CITY OR TOWN <u>Hagerstown</u>	
14. FATHER'S NAME FIRST <u>Thomas B.</u> MIDDLE <u>Haywood</u> LAST <u>M.D.</u>		15. MOTHER'S MAIDEN NAME FIRST <u>Thomas B.</u> MIDDLE <u>Haywood</u> LAST <u>M.D.</u>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO. <u>214073530</u>		17. INFORMANT ADDRESS	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiorespiratory arrest</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>atherosclerotic disease</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>obstructive lung disease</u>					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>minutes</u> <u>years</u> <u>years</u>
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <u>—</u>					
19a. DATE OF OPERATION <u>—</u>		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED <u>—</u>		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. <u>19</u>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from <u>7/9</u> 19 <u>86</u> , to <u>8/4</u> 19 <u>86</u> , that (I) (we) last saw the deceased alive on <u>8/4</u> 19 <u>86</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above; (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE <u>Thomas B. Haywood M.D.</u> DEGREE <u>—</u>				22c. DATE SIGNED <u>8/4/86</u>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <u>Thomas B. Haywood M.D.</u>				22e. ADDRESS <u>645 E. First St., Hagerstown, Md. 21740</u>	
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>burial</u>		23b. DATE <u>Aug. 6, 1986</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Rose Hill Cemetery</u>	
23d. LOCATION CITY OR TOWN <u>Hagerstown, Wash., Maryland</u>		23e. COUNTY <u>Washington</u>		23f. STATE <u>MD.</u>	
24. FUNERAL DIRECTOR NAME <u>MINNICH FUNERAL HOME</u> ADDRESS <u>415 E. Wilson Blvd., Hagerstown, Md. 21740</u>				25a. DATE REC'D. BY REGISTRAR <u>AUG 7 1986</u>	
25b. REGISTRAR'S SIGNATURE <u>James H. Hager</u>				25c. REGISTRAR'S NAME <u>James H. Hager</u>	

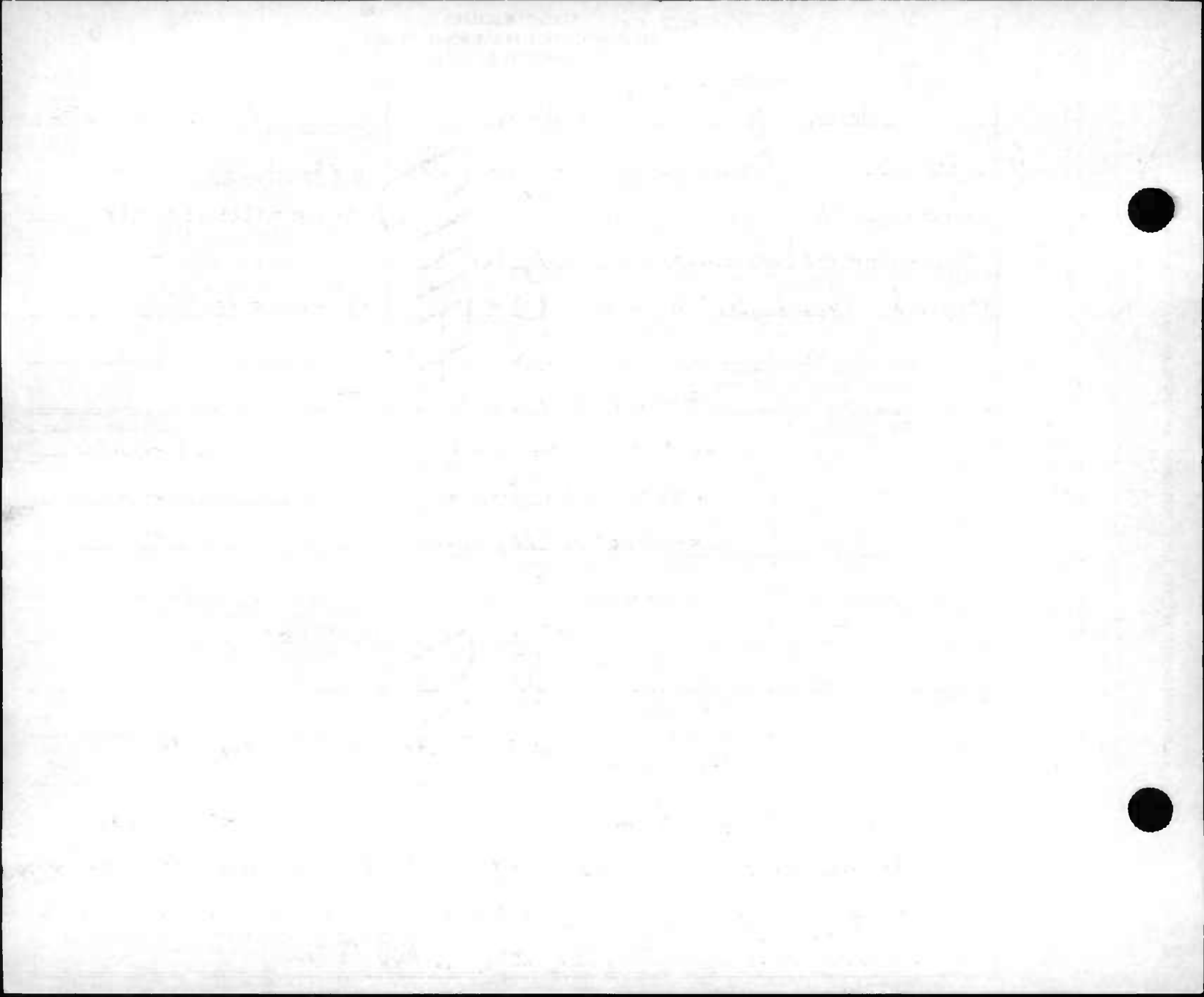
MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be retained and within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked "a", item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP



STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

6 2 4 0 4 7

1- STATE  
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) Blanche Virginia Bowser			2a. DATE OF DEATH MONTH DAY YEAR 8 13 86			2b. HOUR 3 P.M.	
3. SEX Female		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR MAR. 21 1906		6. AGE (IN YEARS LAST BIRTHDAY) 80	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MARYLAND		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Washington MD.	
10. CITY OR TOWN OF DEATH Hagerstown		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 305 O'TOOLE DR.		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) HOUSEWORK		12b. KIND OF BUSINESS OR INDUSTRY HOUSEWIFE	
13a. STATE MARYLAND		13b. COUNTY WASHINGTON		13c. CITY OR TOWN WILLIAMSPORT		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST JOHN RUEBEN CONLEY		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST BESSIE GRUBER CONLEY		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO		16b. SOCIAL SECURITY NO. 213-12-7600	
17. INFORMANT ADDRESS EMMA JANE BOWSER		17. ITEM 13 ABOVE					

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Respiratory failure</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Metastatic carcinoma</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>Endometrial carcinoma</u>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>2 1/2</u> <u>week</u>
---	--	--

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:

19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from <u>11/17</u> 19 <u>82</u> , to <u>8/13</u> 19 <u>86</u> , that (I) (we) last saw the deceased alive on <u>8/13</u> 19 <u>86</u> , and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) did not view the body after death.							
22b. SIGNATURE <u>[Signature]</u>				DEGREE MD		22c. DATE SIGNED 8/13/86	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Rita D. H. MD				22e. ADDRESS 1610 Oak Hill Ave Hagerstown MD			

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL		23b. DATE AUG. 16, 1986		23c. NAME OF CEMETERY OR CREMATORY RIVERVIEW		23d. LOCATION CITY OR TOWN COUNTY STATE WILLIAMSPORT WASH. MD	
24. FUNERAL DIRECTOR NAME MAYOR M. OSBORNE				ADDRESS P.O. BOX 348 MD 21795		25. DATE REC'D. BY REGISTRAR AUG 25 1986	
26. REGISTRAR'S SIGNATURE <u>[Signature]</u>							

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by an attending physician and completely filled in by the funeral director, page 3 should be detached for use in the burial-transit permit. Their place, remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation or removal.  
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

SECRET

CONFIDENTIAL

1. The purpose of this document is to provide a summary of the information received from the source regarding the activities of the group in the area of [illegible] and [illegible].

2. The source has provided information regarding the activities of the group in the area of [illegible] and [illegible]. The source has provided information regarding the activities of the group in the area of [illegible] and [illegible].

3. The source has provided information regarding the activities of the group in the area of [illegible] and [illegible]. The source has provided information regarding the activities of the group in the area of [illegible] and [illegible].

4. The source has provided information regarding the activities of the group in the area of [illegible] and [illegible]. The source has provided information regarding the activities of the group in the area of [illegible] and [illegible].

5. The source has provided information regarding the activities of the group in the area of [illegible] and [illegible]. The source has provided information regarding the activities of the group in the area of [illegible] and [illegible].

6. The source has provided information regarding the activities of the group in the area of [illegible] and [illegible]. The source has provided information regarding the activities of the group in the area of [illegible] and [illegible].

7. The source has provided information regarding the activities of the group in the area of [illegible] and [illegible]. The source has provided information regarding the activities of the group in the area of [illegible] and [illegible].

8. The source has provided information regarding the activities of the group in the area of [illegible] and [illegible]. The source has provided information regarding the activities of the group in the area of [illegible] and [illegible].

9. The source has provided information regarding the activities of the group in the area of [illegible] and [illegible]. The source has provided information regarding the activities of the group in the area of [illegible] and [illegible].

10. The source has provided information regarding the activities of the group in the area of [illegible] and [illegible]. The source has provided information regarding the activities of the group in the area of [illegible] and [illegible].

00-15213

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and properly filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 1 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

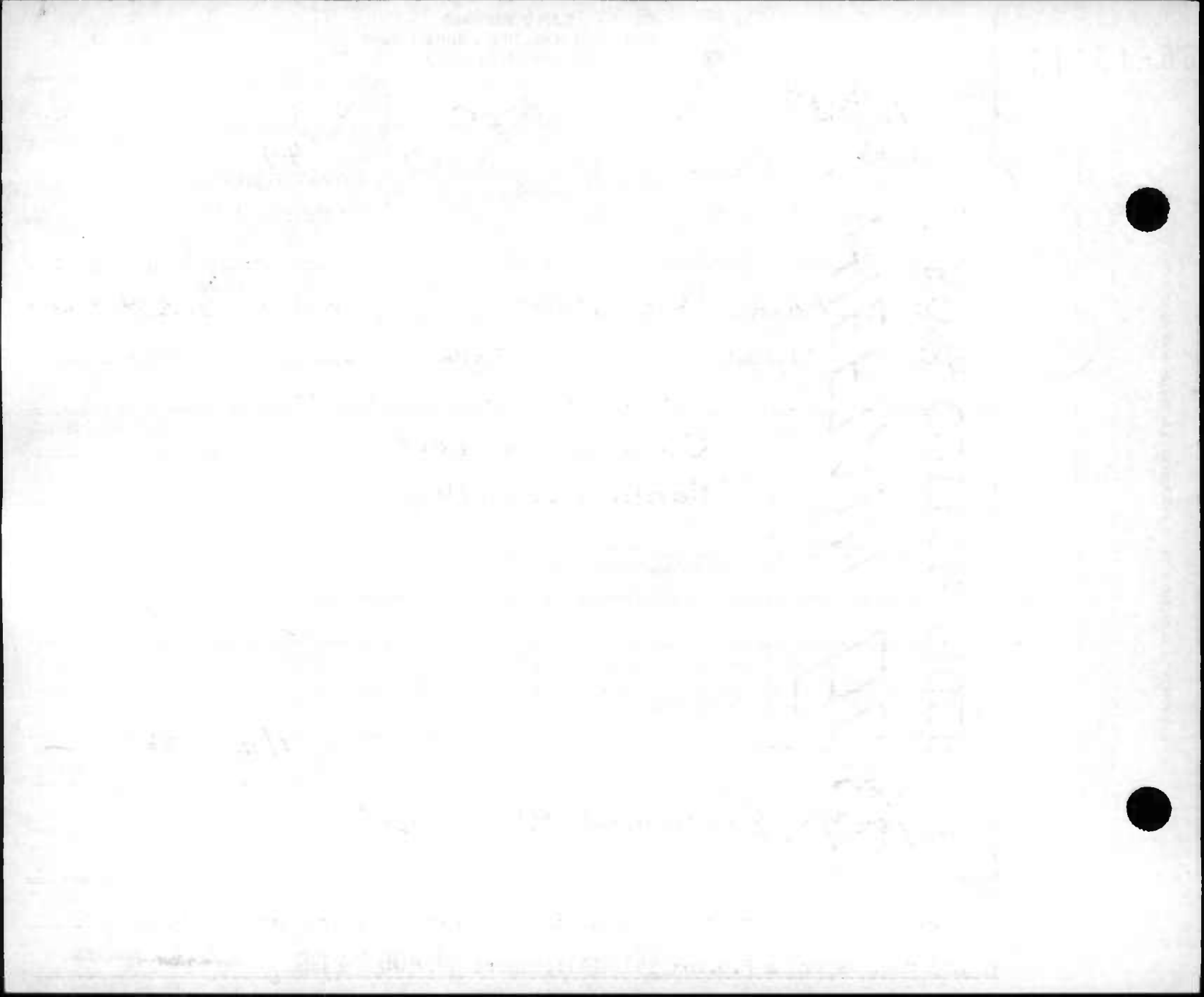
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

24048

1. FOR STATE REGISTRAR				2a. DATE OF DEATH MONTH DAY YEAR				2b. HOUR											
1. DECEASED NAME (TYPE OR PRINT) <b>Ralph Boyer</b>				MIDDLE <b>E. Wood</b>				LAST <b>Boyer</b>				F-9-86				7:00 P.M.			
3. SEX <b>male</b>				4. RACE <b>Cauc</b>				5. DATE OF BIRTH MONTH DAY YEAR <b>3 / 3 37</b>				6. AGE (IN YEARS LAST BIRTHDAY) <b>49</b> YRS.				IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.			
7. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Nagerstown</b>				7b. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>				8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>				9. BALTIMORE CITY OR COUNTY OF DEATH <b>WASH CO.</b> MD.							
10. CITY OR TOWN OF DEATH <b>NAGERSTOWN</b>				11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>WASH CO Hosp.</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Dock Worker</b>				12b. KIND OF BUSINESS OR INDUSTRY <b>Industrial</b>							
13a. STATE <b>MD</b>				13b. COUNTY <b>WASH</b>				13c. CITY OR TOWN <b>NAGERSTOWN</b>				13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>				13e. STREET ADDRESS / ZIP CODE <b>108 G. New Tea Hill Dr.</b>			
14. FATHER'S NAME (TYPE OR PRINT) <b>Carl William Boyer</b>				15. MOTHER'S MAIDEN NAME (TYPE OR PRINT) <b>Thelma Lucinda McCoy</b>															
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>Yes</b>				16b. SOCIAL SECURITY NO. <b>214-34-9212</b>				17. INFORMANT <b>Patsey Boyer</b>				Item 13 above							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cardiac arrest</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: (b) <b>Cardiomyopathy</b> DUE TO, OR AS A CONSEQUENCE OF (c) _____												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:																			
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>							
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. <b>19</b>				21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)											
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)				21f. LOCATION STREET CITY OR TOWN COUNTY STATE											
22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to <b>8/9</b> , 19 <b>86</b> , that (I) (we) saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did not) view the body after death.																			
22b. SIGNATURE <b>George Newman II M.D.</b> DEGREE <b>M.D.</b> ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>												22c. DATE SIGNED							
22d. PHYSICIAN'S NAME (TYPE OR PRINT)												22e. ADDRESS							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>				23b. DATE <b>8-12-86</b>				23c. NAME OF CEMETERY OR CREMATORY <b>Mt. View Cemetery</b>				23d. LOCATION CITY OR TOWN COUNTY STATE <b>Sharpsburg Washington Md.</b>							
24. FUNERAL DIRECTOR NAME <b>Major M. Osborh</b> ADDRESS <b>e P.o. Box 348 Williamsport Md.</b>												25a. DATE REC'D. BY REGISTRAR <b>AUG 14 1986</b>				25b. REGISTRAR'S SIGNATURE <b>Davidson</b>			



0516562

1- FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

24049

1. DECEASED NAME (TYPE OR PRINT) Elizabeth Broedner			2a. DATE OF DEATH MONTH DAY YEAR August 12 86			2b. HOUR 1:30 A.M.				
3. SEX Female		4. RACE Caucasion		5. DATE OF BIRTH MONTH DAY YEAR 8 - 11 - 1891		6. AGE (IN YEARS LAST BIRTHDAY) 95		7. IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Germany		7b. CITIZEN OF WHAT COUNTRY? United States		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Washington County MD.				
10. CITY OR TOWN OF DEATH Hagerstown		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Washington Hospital				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Homemaker		12b. KIND OF BUSINESS OR INDUSTRY Home		
13a. STATE MD			13b. COUNTY Washington		13c. CITY OR TOWN Hagerstown		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 167 Lakeside Drive/21740	
14. FATHER'S NAME FIRST MIDDLE LAST Kasper _____ Mahr			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Margaret _____							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No			16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 573-25-3133			17. INFORMANT ADDRESS Barbara Hummel (Same as # 13)				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>acute pulmonary edema</u> hours DUE TO, OR AS A CONSEQUENCE OF (b) <u>ruptured aortic aneurysm</u> hours DUE TO, OR AS A CONSEQUENCE OF (c) <u>arteriosclerotic heart disease</u>								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: a <u>Arteriosclerosis</u> <u>USA old</u>										
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)				
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE				
22a. I certify that (I) (this hospital) attended the deceased from <u>8/11</u> 19 <u>86</u> , to <u>8/12</u> 19 <u>86</u> , that (I) (we) lost saw the deceased alive on <u>8/11</u> <u>86</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above; (I) (we) (did) (did not) view the body after death.										
22b. SIGNATURE <u>Gloria F. Pura</u>			DEGREE <u>MD</u>			ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED <u>8/12/86</u>		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <u>Gloria F. Pura</u>			22e. ADDRESS <u>339 E. Antietam St. Hagerstown</u>							
23a. BURIAL, CREMATION, REMOVAL Burial			23b. DATE 8 - 15 - 86		23c. NAME OF CEMETERY OR CREMATORY Glen Haven Cemetery		23d. LOCATION Glen Burnie, A. A. MD STATE			
24. FUNERAL DIRECTOR NAME <u>BARRANCO FUNERAL HOME</u>			ADDRESS <u>495 Ritchie Hwy. Severna Park, MD 21146</u>			25a. DATE REC'D. BY REGISTRAR <u>18 AUG 1986</u>		25b. REGISTRAR'S SIGNATURE <u>[Signature]</u>		

MEDICAL CERTIFICATION

99

971925211

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201  
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.  
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP

*[Faint, illegible text covering the majority of the page, likely bleed-through from the reverse side.]*



00-17648

1- FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

24050

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <b>Jessie W. Brown</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>8 28 86</b>			2b. HOUR <b>10:15AM</b>			
3. SEX <b>Female</b>		4. RACE <b>1</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>5 21 96</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>90</b>		7. IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Cripple Cr.</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Washington Co. MD.</b>			
10. CITY OR TOWN OF DEATH <b>Hagerstown</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Washington Co. Hospital</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Homemaker</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>Home</b>	
13a. STATE <b>Maryland</b>			13b. COUNTY <b>Washington</b>		13c. CITY OR TOWN <b>Hagerstown</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
14. FATHER'S NAME FIRST MIDDLE LAST <b>William Wesley Busick</b>			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Sarah Margaret Hines</b>			13e. STREET ADDRESS / ZIP CODE <b>725 S. Potomac Street 21740</b>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>No</b>			16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) <b>219-20-0472</b>		17. INFORMANT <b>Hagerstown, Md.</b> <b>Margaret Lancaster 7 Plumtree Lane</b>				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>CARCINOMA OF PANCREAS</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:									
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from <b>8/13</b> , 19 <b>86</b> , to <b>8/28</b> , 19 <b>86</b> , that (I) (we) last saw the deceased alive on <b>8/28</b> , 19 <b>86</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE <b>Dino J. Delaportas MD</b>						22c. DATE SIGNED <b>8/28/86</b>			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>Dino J. Delaportas</b>						22e. ADDRESS <b>703 Oak Hill Ave, Hagerstown</b>			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>			23b. DATE <b>8-30-86</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Rest Haven Cemetery Hagerstown, Wash. Md.</b>		23d. LOCATION CITY OR TOWN COUNTY STATE		
24. FUNERAL DIRECTOR NAME <b>Gerald N. Minnich</b>			ADDRESS <b>Hagerstown, Maryland</b>			25a. DATE REC'D. BY REGISTRAR <b>SEP 03 1986</b>		25b. REGISTRAR'S SIGNATURE <b>Julia Swinton-Peace</b>	

MEDICAL CERTIFICATION

99  
99  
35  
211  
199  
22

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked on item 18 shows any injury, or other traumatic event, the medical examiner must be notified of one.

BP



STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

6 2 4 0 5 1

1 - FOR  
STATE  
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) <b>Jeannette M. Burks</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>August 30, 1986</b>			2b. HOUR <b>4:30 A</b>				
3. SEX <b>Female</b>		4. RACE <b>White</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>Dec. 18, 1908</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>77</b> YRS		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Virginia</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Washington</b> MD.				
10. CITY OR TOWN OF DEATH <b>Williamsport</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Williamsport Nursing Home</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Practical Nurse</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>Medical</b>		
13a. STATE <b>California</b>		13b. COUNTY <b>Napa</b>		13c. CITY OR TOWN <b>Angwin</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS <b>Pine Breeze Nursing Home</b>		
14. FATHER'S NAME FIRST MIDDLE LAST <b>- - Rodgers</b>			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Jeannette -</b>			16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>no</b>			16b. SOCIAL SECURITY NO. <b>579-09-7035</b>	
17. INFORMANT <b>Jeannette Spoor</b>			ADDRESS <b>124 Benson Dr. Lodi, CA 95240</b>							

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).  
PART 1. DEATH WAS CAUSED BY:IMMEDIATE CAUSE (a) **Breast Cancer**

DUE TO, OR AS A CONSEQUENCE OF

Conditions, if any, which  
gave rise to immediate  
cause (a), stating the  
underlying cause last(b) **Organic Brain Syndrome**

DUE TO, OR AS A CONSEQUENCE OF

(c)

APPROXIMATE INTERVAL  
BETWEEN ONSET AND DEATH

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a

MEDICAL CERTIFICATION

19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from <b>December 8, 1974</b> to <b>August 30, 1986</b> , that (I) (we) last saw the deceased alive on <b>19</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE <b>John R. Melnick</b>				DEGREE <b>MD</b>		22c. DATE SIGNED	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>John R. Melnick</b>				22e. ADDRESS <b>16220 Frederick Road, Gaithersburg, MD 20877</b>		ATTENDING MEDICAL STAFF PHYSICIAN <input checked="" type="checkbox"/> DIRECTOR <input type="checkbox"/> PHYSICIAN <input type="checkbox"/>	

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>Sep. 2, 1986</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Rest Haven Cemetery</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Hagerstown Washington Maryland</b>	
24. FUNERAL DIRECTOR NAME <b>Major M. Osborne Williamsport, MD 21795</b>				25a. DATE REC'D. BY REGISTRAR <b>SEP 3 1986</b>		25b. REGISTRAR'S SIGNATURE <i>[Signature]</i>	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, Pages 1 and 9 should be filed with the 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified promptly.

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

2 4 0 5 2

1. FOR STATE REGISTRAR		1. DECEASED NAME (TYPE OR PRINT)		FIRST Reta	MIDDLE Louise	LAST Burtner	2a. DATE OF DEATH MONTH DAY YEAR August 11 1986		2b. HOUR 1:27 p		
3. SEX Female		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR 12 15 1900		6. AGE (IN YEARS LAST BIRTHDAY) 85 YRS.		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Washington County MD.					
10. CITY OR TOWN OF DEATH Boonsboro		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Reeders Memorial Home		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Teacher		12b. KIND OF BUSINESS OR INDUSTRY Education					
13a. STATE Maryland		13b. COUNTY Washington		13c. CITY OR TOWN Keedysville		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS 1415. main St.			
14. FATHER'S NAME FIRST MIDDLE LAST John A. Miller		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Fannie G. Geeting		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. 218-40-2827		17. INFORMANT ADDRESS Roger E. Burtner Reisterstown, MD 21136			
MEDICAL CERTIFICATION		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>912</i> <i>Severe disorder and severe dementia</i> DUE TO, OR AS A CONSEQUENCE OF (b) <i>Multiple CVA's</i> DUE TO, OR AS A CONSEQUENCE OF (c) <i>Stroke</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>Sudden</i>		
		PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <i>Recent aspiration</i>									
		19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
		21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE							
22a. I certify that (I) (this hospital) attended the deceased from <i>8/11/86</i> 19 <i>82</i> , to <i>8/14/86</i> 19 <i>86</i> , that (I) (we) last saw the deceased alive on <i>8/11/86</i> 19 <i>86</i> , and that in my (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.		22b. SIGNATURE <i>R.L. Kugler MD</i>		DEGREE <i>MD</i>		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) R.L. Kugler MD		22e. ADDRESS 100 Geeting Ln. P.O. Box 246 Keedysville, MD									
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 8/14/86		23c. NAME OF CEMETERY OR CREMATORY Fairview Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Keedysville Washington Md					
24. FUNERAL DIRECTOR <i>Charles M. Brown</i>		ADDRESS 327 W. King St Brown Funeral Home PO Box 821, Martinsburg, WV		25a. DATE REC'D. BY REGISTRAR AUG 18 1986		25b. REGISTRAR'S SIGNATURE <i>John William Rader</i>					

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DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial transit permit. The glue should be removed from the back of the certificate. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked on item 18, a copy of this certificate must be retained by the medical examiner or the coroner.

1- FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

24053

1. DECEASED NAME (TYPE OR PRINT) <b>OLIVE</b> <b>Mary</b> <b>CALLER</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>August 28, 1986</b>		2b. HOUR <b>3:55 AM</b>
3. SEX <b>FEMALE</b>	4. RACE <b>White</b>	5. DATE OF BIRTH MONTH DAY YEAR <b>July 4, 1902</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>84</b> YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Maryland</b>	7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>WASHINGTON County MD.</b>	
10. CITY OR TOWN OF DEATH <b>HAGERSTOWN</b>	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>AVALON MANOR</b>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Housewife</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>Own Home</b>
13a. STATE <b>Maryland</b>	13b. COUNTY <b>Allegany</b>	13c. CITY OR TOWN <b>Barrellsville</b>	13d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	13e. STREET ADDRESS / ZIP CODE <b>Route 1, Box 155 / 21545</b>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>Jacob P. Bridges</b>		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Fannie Blucher</b>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>No</b>		16b. SOCIAL SECURITY NO. <b>215-20-6445</b>		17. INFORMANT ADDRESS <b>Rte 1, Box 129</b> <b>Lawrence Fiorita - Hancock, MD 21750</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Acute pulmonary embolism</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. } (b) <b>Congestive multiple glans</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>peripheral vascular disease</b>					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>Weeks</b> <b>Yrs</b>
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1.					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)	
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) lost saw the deceased alive on _____, 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE <b>W.B. CRAIG</b>		DEGREE <b>MD</b>		22c. DATE SIGNED <b>8-28-86</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>W.B. CRAIG</b>		22e. ADDRESS <b>1933 Va Ave Hagerstown, MD</b>			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>	23b. DATE <b>Aug. 30, 1986</b>	23c. NAME OF CEMETERY OR CREMATORY <b>St. Patricks</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Mt. Savage, Allegany, MD</b>	
24. FUNERAL DIRECTOR NAME <b>John J. Hafer, Jr.</b>		ADDRESS <b>LaVale, MD 21502</b>		25a. DATE REC'D. BY REGISTRAR <b>SEP 8 1986</b>	
				25b. REGISTRAR'S SIGNATURE <b>J. L. Davidson</b>	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

24054

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <b>Mary Winnie CARSON</b>		2a. DATE OF DEATH MONTH DAY YEAR <b>08 20 86</b>		2b. HOUR MIN. <b>2:25p</b>	
3. SEX <b>Female</b>	4. RACE <b>Black</b>	5. DATE OF BIRTH MONTH DAY YEAR <b>10 16 06</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>79</b> YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>MD</b>	7b. CITIZEN OF WHAT COUNTRY? <b>US</b>	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Washington</b> MD.	
10. CITY OR TOWN OF DEATH <b>Hagerstown</b>	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Western Maryland Center</b>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>H/W</b>		12b. KIND OF BUSINESS OR INDUSTRY
13a. STATE <b>MD</b>	13b. COUNTY <b>St. Marys</b>	13c. CITY OR TOWN <b>Pomfret</b>	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE <b>Rt. 2, Box 72D</b> <b>20675</b>
14. FATHER'S NAME <b>XXXX Joseph Bennett</b>		15. MOTHER'S MAIDEN NAME <b>Catherine Gant</b> <b>XXXXXX</b>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>No</b>		16b. SOCIAL SECURITY NO. <b>220-26-6289</b>		17. INFORMANT <b>Rex Carson</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Coronary artery disease</b> Years DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Chronic obstructive pulmonary disease</b> Years DUE TO, OR AS A CONSEQUENCE OF (c) <b>Right cerebrovascular stroke</b> Months					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (c) <b>Diabetes Mellitus, Syndrome of inappropriate anti-diuretic hormone</b>					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>8/1</b> <b>8/20</b> <b>1986</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)	
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE <b>1500 Pennsylvania Avenue Hagerstown, Md 21740</b>	
22a. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <b>8/1</b> <b>8/20</b> <b>1986</b> , and that in (my) <input checked="" type="checkbox"/> opinion death occurred on the date and hour and from the causes stated above, (I) <input checked="" type="checkbox"/> (we) <input type="checkbox"/> view the body after death.					
22b. SIGNATURE <b>Kyung S. Kim, M.D.</b>		DEGREE <b>MD</b>		22c. DATE SIGNED <b>8/21/86</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT)		22e. ADDRESS <b>1500 Pennsylvania Avenue Hagerstown, Md 21740</b>			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>Aug. 23, 86</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Gardens Leonardtown, St Mary's, Md.</b>	
24. FUNERAL DIRECTOR <b>N. Glavin</b>		24a. ADDRESS <b>Leonardtown, Md</b>		25a. DATE REC'D. BY REGISTRAR <b>AUG 26 1986</b>	
				25b. REGISTRAR'S SIGNATURE <b>Lelia Davidson</b>	

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1. FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO. 24055

1. DECEASED NAME (TYPE OR PRINT) <b>JOENDA L COOK</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>8 15 86</b>			2b. HOUR <b>5 35 PM</b>				
3. SEX <b>Female</b>		4. RACE <b>White</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>Dec. 26 1941</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>44</b>		7. IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Maryland</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Washington County</b>			MD.	
10. CITY OR TOWN OF DEATH <b>Hagerstown</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Washington County Hospital</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Asst. Sales Mgr.</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>Staircase</b>		
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 30. STATE <b>Penna.</b>			13b. COUNTY <b>Franklin</b>		13c. CITY OR TOWN <b>Greencastle</b>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE <b>2470 Williamson Rd. 17225</b>	
14. ATER'S NAME FIRST MIDDLE LAST <b>UNKNOWN</b>			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>UNKNOWN</b>							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>No</b>			16b. SOCIAL SECURITY NO. <b>213-42-2065</b>		17. INFORMANT ADDRESS <b>Darwin C. Cook Sr. 2470 Williamson Rd. Greencastle, PA</b>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>CARDIO RESPIRATORY</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>METASTATIC CARCINOMA of the</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO, OR AS A CONSEQUENCE OF (c) <b>BREAST</b>										
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)										
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)				
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT HOME <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE				
22a. I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) lost saw the deceased alive on _____, 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.										
22b. SIGNATURE <b>ED WOOSTER MD</b>						DEGREE <b>MD</b>		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED <b>8/15/86</b>
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>ED WOOSTER</b>						22e. ADDRESS <b>1825 Howell Rd Hagerstown MD</b>				
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>			23b. DATE <b>8/18/1986</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Quincy Cemetery</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Quincy Twp., Franklin, Penna.</b>			
24. FUNERAL DIRECTOR NAME <b>Darwin Cook</b>			ADDRESS <b>50 S. Broad St. Waynesboro, Pa.</b>		25a. DATE REC'D. BY REGISTRAR <b>AUG 20 1986</b>		25b. REGISTRAR'S SIGNATURE <b>John F. ...</b>			

MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified or called.

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00-17505

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM. 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

24056  
REG. NO.FOR  
1- STATE  
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) <b>JOSEPH unknown DESTRA</b>			2a. DATE KNOWN OF DEATH ESTI. MATED <input checked="" type="checkbox"/> MONTH <input type="checkbox"/> DAY <input type="checkbox"/> YEAR <b>8/30/86</b>		2b. HOUR <b>5:40 PM</b>
3. SEX <b>male</b>	4. RACE <b>Haitian</b>	5. DATE OF BIRTH MONTH DAY YEAR <b>unknown</b>	6. AGE (IN YEARS) LAST BIRTHDAY <b>unknown</b>	IF UNDER 1 YR. MONTHS DAYS	IF UNDER 24 HRS. HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Haiti</b>	7b. CITIZEN OF WHAT COUNTRY? <b>Haiti</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Washington</b>
10. CITY OR TOWN OF DEATH <b>Hagerstown</b>	11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE RESIDENCE ADDRESS) <b>Washington County Hospital</b>			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>fruit picker</b>	12b. KIND OF BUSINESS OR INDUSTRY
USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)					
13a. STATE <b>unknown</b>	13b. COUNTY <b>unknown</b>	13c. CITY OR TOWN <b>unknown</b>	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>	13e. STREET ADDRESS <b>unknown</b>	<b>79999</b>
14. FATHER'S NAME FIRST MIDDLE LAST <b>unknown</b>			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>unknown</b>		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) <b>unknown</b>		16b. SOCIAL SECURITY NO. <b>unknown</b>		17. INFORMANT ADDRESS <b>Hagerstown, Md.</b> <b>Dr. Milic, M.E., Wash. Co. Hosp.,</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>8169 FRACTURE NECK/VERTERRA - N-805</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>MOTOR VEHICLE RAN OFF ROAD - E-816</b> DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH					
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?			20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH P.M. 19		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> .					
ACTUAL SIGNATURE <b>George Milic</b>		TITLE (SPECIFY) <b>DEPUTY</b>		DATE SIGNED <b>8/30/86</b>	
EXAMINER'S NAME (TYPE OR PRINT) <b>GEORGE MILIC, MD</b>		ADDRESS <b>40 MANOR DRIVE #103 HAGERSTOWN - MD - 21740</b>			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>cremation</b>	23b. DATE <b>Sept. 4, 1986</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Smithsburg Crematory</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Smithsburg, Wash., Maryland</b>	
24. FUNERAL DIRECTOR NAME ADDRESS <b>MINNICH FUNERAL HOME 415 E. Wilson Blvd., Hagerstown, Md. 21740</b>		25a. DATE REC'D. BY REGISTRAR <b>SEP 09 1986</b>		25b. REGISTRAR'S SIGNATURE <b>Julia Gordon-Rudner</b>	

07/84  
25M

BP

DHMM - 17  
(VR A15 ME (5))



00-15354

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. There please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										REG. NO. 24057			
1. DECEASED NAME (TYPE OR PRINT)			FIRST	MIDDLE	LAST	2a. DATE OF DEATH			MONTH	DAY	YEAR	2b. HOUR	
Ida Catherine DRAPER						August 9, 1986						M	
3. SEX			4. RACE			5. DATE OF BIRTH			6. AGE (IN YEARS) (LAST BIRTHDAY)			7. IF UNDER 1 YEAR	
female			white			July 26, 1902			84 YRS			MONTHS DAYS HOURS MIN	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)			7b. CITIZEN OF WHAT COUNTRY?			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH			10. MD.	
Maryland			U.S.A.						Washington				
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY				
Hagerstown			Washington County Hospital			secretary			government				
13a. STATE			13b. COUNTY			13c. CITY OR TOWN			13d. INSIDE CITY LIMITS?			13e. STREET ADDRESS / ZIP CODE	
Maryland			Washington			Hagerstown			YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			523 Summit Avenue 21740	
14. FATHER'S NAME (TYPE OR PRINT)			15. MOTHER'S MAIDEN NAME										
Daniel Webster Baker			Clara Lillian Bowders										
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)			16b. SOCIAL SECURITY NO.			17. INFORMANT			ADDRESS				
no						Mr. John D. Scott, Hagerstown, Maryland							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiopulmonary arrest</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: (b) <u>atherosclerotic cardiovascular disease</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>Diabetes mellitus</u>										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a): <u>Respiratory failure, pulmonary edema</u>													
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?				
						YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			YES <input type="checkbox"/> NO <input type="checkbox"/>				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE							
22a. I certify that (1) this hospital attended the deceased from <u>8/8</u> 19 <u>86</u> to <u>8/9</u> 19 <u>86</u> that (1) <del>the</del> last saw the deceased alive on <u>8/8</u> 19 <u>86</u> , and that in (my) <del>own</del> opinion death occurred on the date and hour and from the causes stated above; (2) <del>the</del> I did not view the body after death.													
22b. SIGNATURE <u>George Newman II</u>			DEGREE			ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22c. DATE SIGNED				
22d. PHYSICIAN'S NAME (TYPE OR PRINT)			22e. ADDRESS										
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)			23b. DATE			23c. NAME OF CEMETERY OR CREMATORY			23d. LOCATION CITY OR TOWN COUNTY STATE				
burial			Aug. 12, 1986			Rest Haven Cemetery			Hagerstown, Wash., Maryland				
24. FUNERAL DIRECTOR NAME ADDRESS			25a. DATE REC'D. BY REGISTRAR			25b. REGISTRAR'S SIGNATURE							
MINNICH FUNERAL HOME 415 E. Wilson Blvd., Hagerstown, Maryland 21740			AUG 13 1986			<u>[Signature]</u>							

BP

How do you feel about it?

It's a very good idea.

What do you think?

I think it's a very good idea.

Ph

Ph

Ph

Ph



00-16309

FOR  
1. STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

24058

1. DECEASED NAME (TYPE OR PRINT) <b>Calvin Gardner Drenner</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>August 23, 1986</b>		2b. HOUR <b>6:45a m</b>
3. SEX <b>Male</b>	4. RACE <b>White</b>	5. DATE OF BIRTH MONTH DAY YEAR <b>Sept. 26, 1921</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>64</b> YRS.	IF UNDER 1 YEAR MONTHS DAYS IF UNDER 74 HRS HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Sharpsburg, Md.</b>	7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Washington</b> MD.	
10. CITY OR TOWN OF DEATH <b>Hagerstown</b>	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>412 Indiana Ave.</b>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>machinists</b>	12b. KIND OF BUSINESS OR INDUSTRY <b>Black Truck</b>	
13a. STATE <b>Maryland</b>			13b. COUNTY <b>Washington</b>	13c. CITY OR TOWN <b>Hagerstown</b>	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
14. FATHER'S NAME FIRST MIDDLE LAST <b>Martin Luther Drenner</b>			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Elizabeth Ann Bowers</b>		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>no</b>		16b. SOCIAL SECURITY NO. <b>213 16 1173</b>		17. INFORMANT ADDRESS <b>Eula B. Drenner see # 13 above</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Multiple myeloma</b> DUE TO, OR AS A CONSEQUENCE OF (b) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO, OR AS A CONSEQUENCE OF (c) _____					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>5 years</b>
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: _____					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1B, PART I OR PART 2)	
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE <b>8/23 86</b>	
22a. I certify that (I) (this hospital) attended the deceased from <b>8/23</b> , 19 <b>86</b> , to <b>8/23</b> , 19 <b>86</b> , that (I) (we) lost saw the deceased alive on <b>8/23</b> , 19 <b>86</b> , and that in my (our) opinion death occurred on the date and hour and from the causes stated above (we) (did) (did not) view the body after death.					
22b. SIGNATURE <b>Frederic A. Kass III</b>		DEGREE <b>MD</b>		22c. DATE SIGNED <b>8/23/86</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>Frederic H. Kass III</b>		22e. ADDRESS <b>1825 Howell Rd Hagerstown Md</b>			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>	23b. DATE <b>8/26/86</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Cedar Lawn Mem. Pk.</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Hagerstown, Maryland</b>	
24. FUNERAL DIRECTOR NAME <b>Gerald N. Minnich</b>		HAGERSTOWN, Maryland		25a. DATE REC'D. BY REGISTRAR <b>AUG 26 1986</b>	

MEDICAL CERTIFICATION

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 22 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

WELTON BOO



*[Faint, mostly illegible text, likely bleed-through from the reverse side of the page. Some words like 'subject', 'information', and 'person' are faintly visible.]*

00-15767

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

DHMH - 16 60M 7/84  
(VRA 15, 4)FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

24059

1. DECEASED NAME (TYPE OR PRINT) <b>Rhoda Eleanor EICHELBERGER</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>August 13, 1986</b>			2b. HOUR <b>10:15 P M</b>			
3. SEX <b>female</b>		4. RACE <b>white</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>June 2, 1898</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>88</b> YRS.		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN. IF UNDER 24 HRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Maryland</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Washington</b> MD.			
10. CITY OR TOWN OF DEATH <b>Hagerstown</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Colton Villa Nursing Home</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>housewife</b>		12b. KIND OF BUSINESS OR INDUSTRY	
13a. STATE <b>Maryland</b>		13b. COUNTY <b>Washington</b>		13c. CITY OR TOWN <b>Hagerstown</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE <b>55 Manor Dr. 21740</b>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>George Grantland Stitley</b>				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Virginia Irene Wolfe</b>					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>No</b>				16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) <b>219-20-4109</b>		17. INFORMANT ADDRESS <b>Rhoda E. Eichelberger</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>ARTERIOSCLEROTIC CARDIOVASCULAR DISEASE</b> <b>AND</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>BRONCHOPNEUMONIA</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>MANY YEARS</b> <b>5 - 7 DAYS</b>									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: _____									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE <b>217 WEST WASHINGTON STREET HAGERSTOWN, MARYLAND 21740</b>					
22a. I certify that (I) ( <del>XXXXXX</del> ) attended the deceased from <b>AUG. 13</b> , 19 <b>86</b> , to <b>AUG. 13</b> , 19 <b>86</b> , that (I) <del>xx</del> lost saw the deceased alive on <b>DID NOT SEE</b> , 19 _____, and that in (my) ( <del>xx</del> ) opinion death occurred on the date and hour and from the causes stated above, (I) <del>xx</del> (did) <del>XXXXXX</del> view the body after death.									
22b. SIGNATURE <i>Edward W. Ditto</i> DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>								22c. DATE SIGNED <b>AUG. 15, 1986</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>EDWARD W. DITTO, III, M.D.</b>								22e. ADDRESS <b>217 WEST WASHINGTON STREET HAGERSTOWN, MARYLAND 21740</b>	
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>burial</b>		23b. DATE <b>Aug. 16, 1986</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Rest Haven Cemetery</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Hagerstown, Wash., Maryland</b>			
24. FUNERAL DIRECTOR NAME ADDRESS <b>MINNICH FUNERAL HOME 415 E. Wilson Blvd., Hagerstown, Maryland 21740</b>						25a. DATE REC'D. BY REGISTRAR <b>AUG 18 1986</b>		25b. REGISTRAR'S SIGNATURE <i>[Signature]</i>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

MEDICAL CERTIFICATION

1001

1001

1001



BRADY 1001

BRADY 1001

BRADY 1001

BRADY 1001

BRADY 1001

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BRADY 1001

0-16986

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 24 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										24060	
1. FOR STATE REGISTRAR		Hazel Ruth Ford		2a. DATE OF DEATH		MONTH DAY YEAR		2b. HOUR			
1. DECEASED NAME (TYPE OR PRINT)		Hazel Ruth Ford		2a. DATE OF DEATH		8-30-86		2b. HOUR 9:50 AM			
3. SEX Female		4. RACE White		5. DATE OF BIRTH		MONTH DAY YEAR		6. AGE (IN YEARS LAST BIRTHDAY)			
				May 27 1896		90		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH		10. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			
Maryland		U.S.A.				Washington		Housewife			
11. CITY OR TOWN OF DEATH		12. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		13a. STREET ADDRESS / ZIP CODE		14. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)		15. KIND OF BUSINESS OR INDUSTRY			
Boonsboro Md.		Fahrney Keedy Home		50 North Main Street		Md.					
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET ADDRESS / ZIP CODE			
Md.		Washington		Keedysville		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		21756			
14. FATHER'S NAME		15. MOTHER'S MAIDEN NAME		16. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT			
Jonas L. Jones		Mary Lopp		No		214-36-0396		Ernestine Gordon Keedysville, Maryland			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)		19. DUE TO, OR AS A CONSEQUENCE OF		20. CONDITIONS, IF ANY, WHICH GAVE RISE TO IMMEDIATE CAUSE (a), STATING THE UNDERLYING CAUSE LAST.		21. DUE TO, OR AS A CONSEQUENCE OF		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
Cerebral Aneurysm Rupture											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?					
				YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)							
		HOUR A.M. MONTH DAY YEAR									
		P.M. 19									
21d. INJURY OCCURRED		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION		CITY OR TOWN		COUNTY STATE			
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>				3-M-80							
22a. I certify that (I) (this hospital) attended the deceased from		19		to		19		that (I) (we) last saw the deceased alive on			
		19						and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.			
22b. SIGNATURE		DEGREE		ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		23. DATE SIGNED					
E. J. Ford						8-30-86					
22c. PHYSICIAN'S NAME (TYPE OR PRINT)		22d. ADDRESS		23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY			
E. J. Ford		384 Lake View Rd, Boonsboro Md.		Burial		September 2 1986		Boonsboro Cemetery Boonsboro Washington Md.			
24. FUNERAL DIRECTOR		25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE							
Bast Funeral Home Boonsboro, Maryland 21713		SEP 4 1986									

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to the same place as the other two, and the third, which is the same as the other two, is the same as the other two.

Best of the same kind, and the same as the other two, is the same as the other two. The same as the other two, is the same as the other two.

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1- FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH24061  
REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <i>Thelma Marie GORDON</i>			2a. DATE OF DEATH MONTH DAY YEAR <i>July 28, 1986</i>		2b. HOUR M
3. SEX <i>female</i>	4. RACE <i>white</i>	5. DATE OF BIRTH MONTH DAY YEAR <i>May 1, 1918</i>		6. AGE (IN YEARS LAST BIRTHDAY) <i>68</i>	IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <i>Maryland</i>	7b. CITIZEN OF WHAT COUNTRY? <i>USA</i>	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <i>Washington</i> MD	
10. CITY OR TOWN OF DEATH <i>Hagerstown</i>	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <i>1253 Crescent Road</i>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <i>cook</i>		12b. KIND OF BUSINESS OR INDUSTRY
13a. STATE <i>Maryland</i>	13b. COUNTY <i>Washington</i>	13c. CITY OR TOWN <i>Hagerstown</i>	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET ADDRESS / ZIP CODE <i>1253 CRESCENT Road 21740</i>	
14. FATHER'S NAME FIRST MIDDLE LAST <i>Clifford R. Shilling</i>		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <i>Bessie Good</i>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <i>No</i>		16b. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS <i>Clarence M. Gordon, Hagerstown, Maryland</i>	

18. CAUSE OF DEATH: Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Cardiac Arrest</i>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>Immediate</i>
DUE TO, OR AS A CONSEQUENCE OF, Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) <i>Myocardial Infarction</i>		<i>Immediate</i>
DUE TO, OR AS A CONSEQUENCE OF (c) <i>Arteriosclerotic Heart Disease</i>		<i>Years</i>

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <i>P.M. 19</i>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1B, PART I OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from <i>Oct</i> 19 <i>72</i> , to <i>July</i> 19 <i>86</i> , that (I) (we) last saw the deceased alive on <i>July</i> 19 <i>86</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE <i>W. N. Fender</i>		DEGREE <i>M.D.</i>		22c. DATE SIGNED <i>29 July 1986</i>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <i>W. N. Fender</i>		22e. ADDRESS <i>138 E. Antietam St., Hagerstown, Md.</i>			

23a. BURIAL, CREMATION, REMOVAL SPECIFY <i>burial</i>	23b. DATE <i>July 24, 1986</i>	23c. NAME OF CEMETERY OR CREMATORY <i>Cedar Lawn Mem. Park</i>	23d. LOCATION CITY OR TOWN COUNTY STATE <i>Hagerstown, Wash., Maryland</i>
24. FUNERAL DIRECTOR NAME ADDRESS <i>MINNICH FUNERAL HOME 415 E. Wilson Blvd., Hagerstown, Md. 21740</i>			25a. DATE REC'D. BY REGISTRAR <i>AUG 01 1986</i>
			25b. REGISTRAR'S SIGNATURE <i>Julia Fender-Randall</i>

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 48 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed in full by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.  
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified and a post-mortem examination required.

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NOTICE

15151





000-15148

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 24 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified immediately.

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

24062

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <u>Madeline L. HIMES</u>		2a. DATE OF DEATH MONTH DAY YEAR <u>August 10, 1986</u>		2b. HOUR <u>8:30</u> AM	
3. SEX <u>FEMALE</u>		4. RACE <u>WHITE</u>		5. DATE OF BIRTH MONTH DAY YEAR <u>09 26 1925</u>	
6. AGE YEARS (LAST BIRTHDAY) <u>60</u>		7. CITIZEN OF WHAT COUNTRY? <u>USA</u>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <u>MD</u>		9. BALTIMORE CITY OR COUNTY OF DEATH <u>Washington</u>		10. CITY OR TOWN OF DEATH <u>Williamsport</u>	
11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <u>Williamsport Nursing Home</u>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <u>Housewife</u>		12b. KIND OF BUSINESS OR INDUSTRY	
13a. STATE <u>MD</u>		13b. COUNTY <u>FREDERICK</u>		13c. CITY OR TOWN <u>KNOXVILLE</u>	
14. FATHER'S NAME FIRST MIDDLE LAST <u>JAMES L. MYERS</u>		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <u>M. IRENE GRUBB</u>		16. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, TWO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) <u>NO</u> <u>N/A</u>	
17. INFORMANT ADDRESS <u>Brenda Swiger 3712 Poffenberger Rd. Jefferson, MD</u>		18. SOCIAL SECURITY NO. <u>216-22-7758</u>		19. DATE OF OPERATION <u>4-20</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardio-pulmonary Arrest</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Cardio-myocardial Infarction</u> DUE TO, OR AS A CONSEQUENCE OF (c) _____		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) _____		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		21. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <u>19</u>		21c. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. LOCATION STREET CITY OR TOWN COUNTY STATE		22. I certify that (I) ( <del>this hospital</del> ) attended the deceased from <u>4-20</u> , 19 <u>82</u> , to <u>8-10</u> , 19 <u>86</u> , that (I) ( <del>was</del> ) last saw the deceased alive on <u>7-31</u> , 19 <u>86</u> , and that in (my) ( <del>how</del> ) opinion death occurred on the date and hour and from the causes stated above, (I) ( <del>may not</del> ) (did not) view the body after death.	
22a. SIGNATURE <u>John R. Melnick</u>		DEGREE <u>MD</u>		22c. DATE SIGNED	
22b. PHYSICIAN'S NAME (TYPE OR PRINT) <u>John R. Melnick</u>		22d. ADDRESS <u>16220 Frederick Road Gaithersburg, MD 20877</u>		23. NAME OF CEMETERY OR CREMATORY <u>Jefferson Reformed</u>	
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		23b. DATE <u>8/13/86</u>		23c. LOCATION CITY OR TOWN COUNTY STATE <u>Jefferson Frederick MD</u>	
24. FUNERAL DIRECTOR NAME <u>G. Douglas Stauffer</u>		25. DATE REC'D. BY REGISTRAR <u>AUG 12 1986</u>		26. REGISTRAR'S SIGNATURE <u>Julia Davidson</u>	
24b. ADDRESS <u>1621 Opossumtown Pike, Frederick, MD</u>					

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1- FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH24063  
REG. NO.

1. DECEASED NAME (TYPE OR PRINT) <b>Betty Gladys Hoffman</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>8 29 86</b>			2b. HOUR <b>8:55 P.M.</b>				
3. SEX <b>Female</b>		4. RACE <b>White</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>Feb. 2, 1924</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>62</b>		7. IF UNDER 1 YEAR MONTHS DAYS <b>YRS.</b>		
8a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Pennsylvania</b>		8b. CITIZEN OF WHAT COUNTRY? <b>USA</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>WASHINGTON</b>			MD	
10. CITY OR TOWN OF DEATH <b>Hagerstown</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Washington County Hospital</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Adv. Manager</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>Merchandise</b>		
13a. STATE <b>Maryland</b>			13b. COUNTY <b>Washington</b>		13c. CITY OR TOWN <b>Hagerstown</b>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE <b>104 E. Lincoln St. 21740</b>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>Robert - Worthing</b>				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Wyzetta - Davis</b>						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>no</b>		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) <b>210-18-7784</b>		17. INFORMANT ADDRESS <b>Paul P. Hoffman (item 13 above)</b>						

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).  
PART 1. DEATH WAS CAUSED BY:IMMEDIATE CAUSE (a) **Respiratory arrest**

DUE TO, OR AS A CONSEQUENCE OF

Conditions, if any, which  
gave rise to immediate  
cause (a), stating the  
underlying cause lost.(b) **Intracerebral clot**

DUE TO, OR AS A CONSEQUENCE OF

(c)

APPROXIMATE INTERVAL  
BETWEEN ONSET AND DEATH**8 days.**

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a):

19a. DATE OF OPERATION <b>8/22/86</b>		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED <b>Intracerebral clot.</b>		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1B PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from <b>8/22/86</b> to <b>8/29 86</b> that (I) (we) lost saw the deceased alive on <b>8/29 86</b> , and that (I) (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) view the body after death.							
22b. SIGNATURE <b>A.F. Abdullah</b>				DEGREE <b>M.D.</b>		22c. DATE SIGNED	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>A.F. Abdullah</b>				22e. ADDRESS <b>318 N. Potomac, Hagerstown MD.</b>			

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>Sep. 2, 1986</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Cedar Lawn Mem. Park</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Hagerstown Washington Maryland</b>	
24. FUNERAL DIRECTOR NAME ADDRESS <b>Major M. Osborne Williamsport, MD 21795</b>				25a. DATE REC'D. BY REGISTRAR <b>SEP 3 1986</b>		25b. REGISTRAR'S SIGNATURE <b>[Signature]</b>	

MEDICAL CERTIFICATION

29

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be mailed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner should be notified.

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EXHIBIT

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified and

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

24064

1. FOR STATE REGISTRAR		2a. DATE OF DEATH		2b. HOUR	
1. DECEASED NAME (TYPE OR PRINT)		MONTH DAY YEAR		HOURS MIN.	
FIRST MIDDLE LAST		Aug. 8 1986		12:40 a	
Clarence A. Holmes					
3. SEX		4. RACE		5. DATE OF BIRTH	
Male		White		MONTH DAY YEAR	
				June 12 1893	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		6. AGE (IN YEARS LAST BIRTHDAY)	
Chestnut Grove, Md.		U. S. A.		93 YRS.	
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		9. BALTIMORE CITY OR COUNTY OF DEATH	
Boonsboro		Reeders Memorial Home		Washington County MD.	
12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY			
Farmer		Farming			
13a. STATE		13b. COUNTY		13c. CITY OR TOWN	
Maryland		Washington		Keedysville	
14. FATHER'S NAME		15. MOTHER'S MAIDEN NAME			
FIRST MIDDLE LAST		FIRST MIDDLE LAST			
Frederick Holmes		Margaret Mc Allister			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT	
No		220-10-3925		Gilbert Holmes, Keedysville, Md. 21756	
18. CAUSE OF DEATH (Enter only one cause per line. List all, if more than one.)		19. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	
PART 1. DEATH WAS CAUSED BY:					
IMMEDIATE CAUSE (a)					
DUE TO, OR AS A CONSEQUENCE OF					
(b)					
DUE TO, OR AS A CONSEQUENCE OF					
(c)					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1					
Hemiparesis due to CVA, peripheral 15 chimeria, renal failure, ileus					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		20b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M.		20c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)	
		19			
21a. INJURY OCCURRED		21b. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21c. LOCATION STREET CITY OR TOWN COUNTY STATE	
WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>					
22a. I certify that (I) (this hospital) attended the deceased from 19 82, to 19 82, that (I) (we) last saw the deceased alive on 8/8/86, 19 86, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.		22b. SIGNATURE		22c. DATE SIGNED	
		DEGREE			
		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			
22d. PHYSICIAN'S NAME (TYPE OR PRINT)		22e. ADDRESS			
R. L. Kugler, MD		1006 Geeting Ln. Keedysville, Md.			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY	
Burial		8-11-86		Samples Manor Cemetery	
24. FUNERAL DIRECTOR		25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE	
NAME ADDRESS		AUG 11 1986		John H. Bast, Jr. Boonsboro, Md. 21713	
John H. Bast, Jr. Boonsboro, Md. 21713					

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Sampled Nether Cemetery

John H. Bost, Jr.

Boonshoro, N.Y. 2171

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11.1 Box 100 2172

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Friedrich

Holmes

Holmes

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00-14861

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

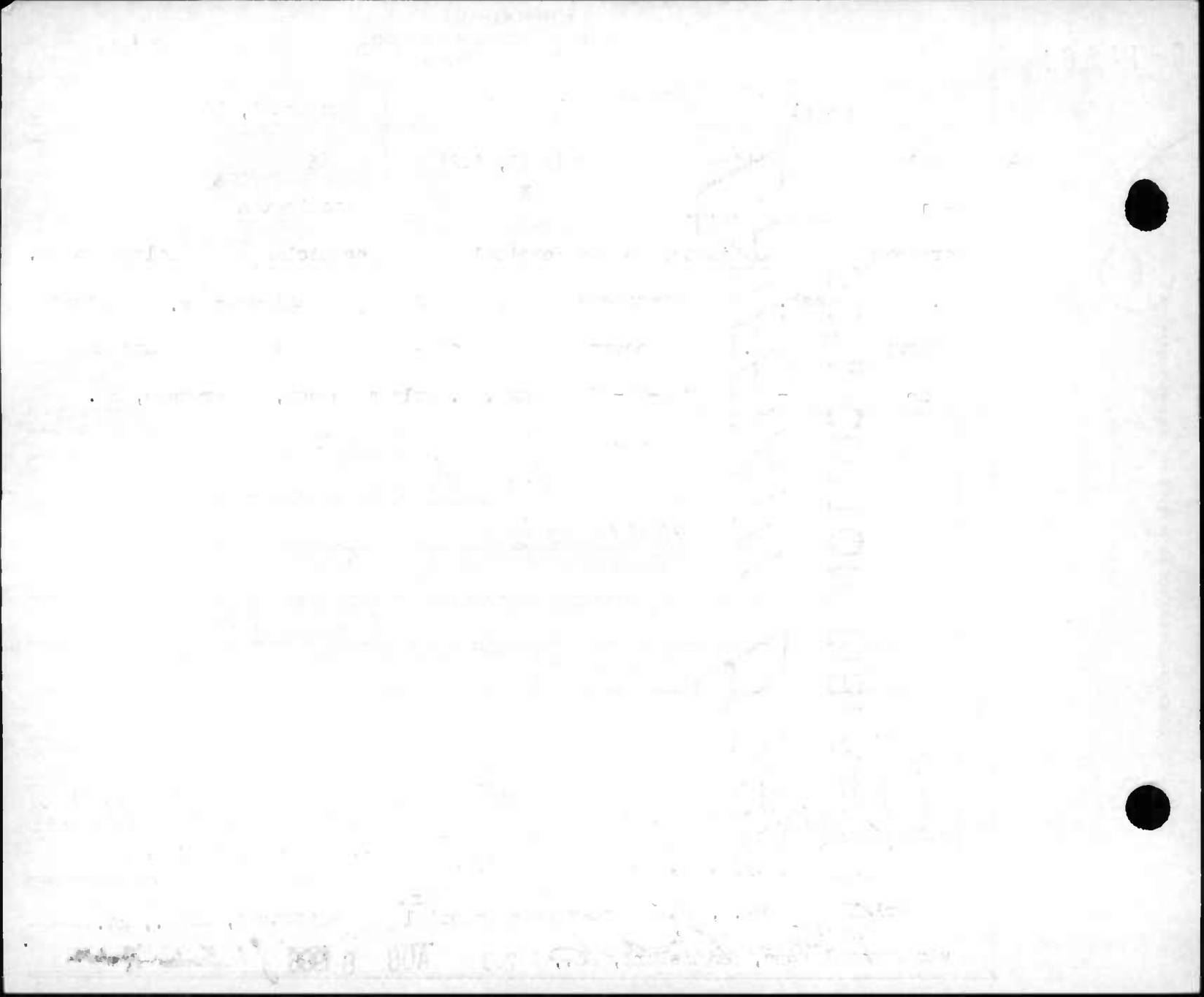
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 24 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

DHMH - 16 60M 7/84  
(VRA 15, 4)

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										24065	
1. FOR STATE REGISTRAR		2a. DATE OF DEATH						2b. HOUR			
1. DECEASED NAME (TYPE OR PRINT)		2a. DATE OF DEATH MONTH DAY YEAR						2b. HOUR			
Marvin		August 1, 1986						M			
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)		IF UNDER 1 YEAR			
Male		White		MONTH DAY YEAR		65		MONTHS DAYS HOURS MIN.			
7b. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7c. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH		10. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			
Maryland		U.S.A.				Washington		Technician			
11. CITY OR TOWN OF DEATH		12. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		13a. STREET ADDRESS / ZIP CODE		13b. STREET ADDRESS / ZIP CODE		14. KIND OF BUSINESS OR INDUSTRY			
Hagerstown		Washington County Hospital		306 Robinwood Dr.		21740		Telephone Co.			
15. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)		16. CITY OR TOWN		17. INSIDE CITY LIMITS?		18. STREET ADDRESS / ZIP CODE		19. STREET ADDRESS / ZIP CODE			
Md.		Hagerstown		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		306 Robinwood Dr.		21740			
20. FATHER'S NAME		21. MOTHER'S MAIDEN NAME		22. INFORMANT		23. ADDRESS		24. ADDRESS			
Harry		Leida		Mrs. H. Arlene Hoover		Hagerstown, Md.		Hagerstown, Md.			
25. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		26. SOCIAL SECURITY NO.		27. INFORMANT		28. ADDRESS		29. ADDRESS			
NO		219-14-7534		Mrs. H. Arlene Hoover		Hagerstown, Md.		Hagerstown, Md.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)											
PART 1. DEATH WAS CAUSED BY:											
IMMEDIATE CAUSE (a): <u>CARDIORESPIRATORY ARREST</u>											
DUE TO, OR AS A CONSEQUENCE OF (b): <u>CONGESTIVE HEART FAILURE</u>											
DUE TO, OR AS A CONSEQUENCE OF (c): <u>RENAL FAILURE</u>											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?			
						YES <input type="checkbox"/> NO <input type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)		21d. PLACE OF INJURY		21e. LOCATION			
		HOUR A.M. MONTH DAY YEAR				CITY OR TOWN		COUNTY STATE			
21f. INJURY OCCURRED		21g. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21h. LOCATION		CITY OR TOWN		COUNTY STATE			
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>											
22. I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) lost the deceased alive on _____, 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (dd) (did not) view the body after death.											
22a. SIGNATURE		22b. DEGREE				22c. DATE SIGNED		22d. DATE SIGNED			
L.D. WOOSTER M.D.		ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>				8/4/86		8/4/86			
22e. PHYSICIAN'S NAME (TYPE OR PRINT)		22f. ADDRESS				22g. ADDRESS		22h. ADDRESS			
L.D. WOOSTER		1225 HOWELL RD HAGERSTOWN				1225 HOWELL RD HAGERSTOWN		1225 HOWELL RD HAGERSTOWN			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION		23e. LOCATION			
Burial		Aug. 4, 1986		Cedar Lawn Memorial		Hagerstown, Wash. Md.		Hagerstown, Wash. Md.			
24. FUNERAL DIRECTOR		25. DATE RECEIVED BY REGISTRAR				25b. REGISTRAR'S SIGNATURE		25c. REGISTRAR'S SIGNATURE			
Davis Funeral Home, Smithsburg, Md.		AUG 8 1986				J. L. Davidson		J. L. Davidson			

BP





0-16430

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

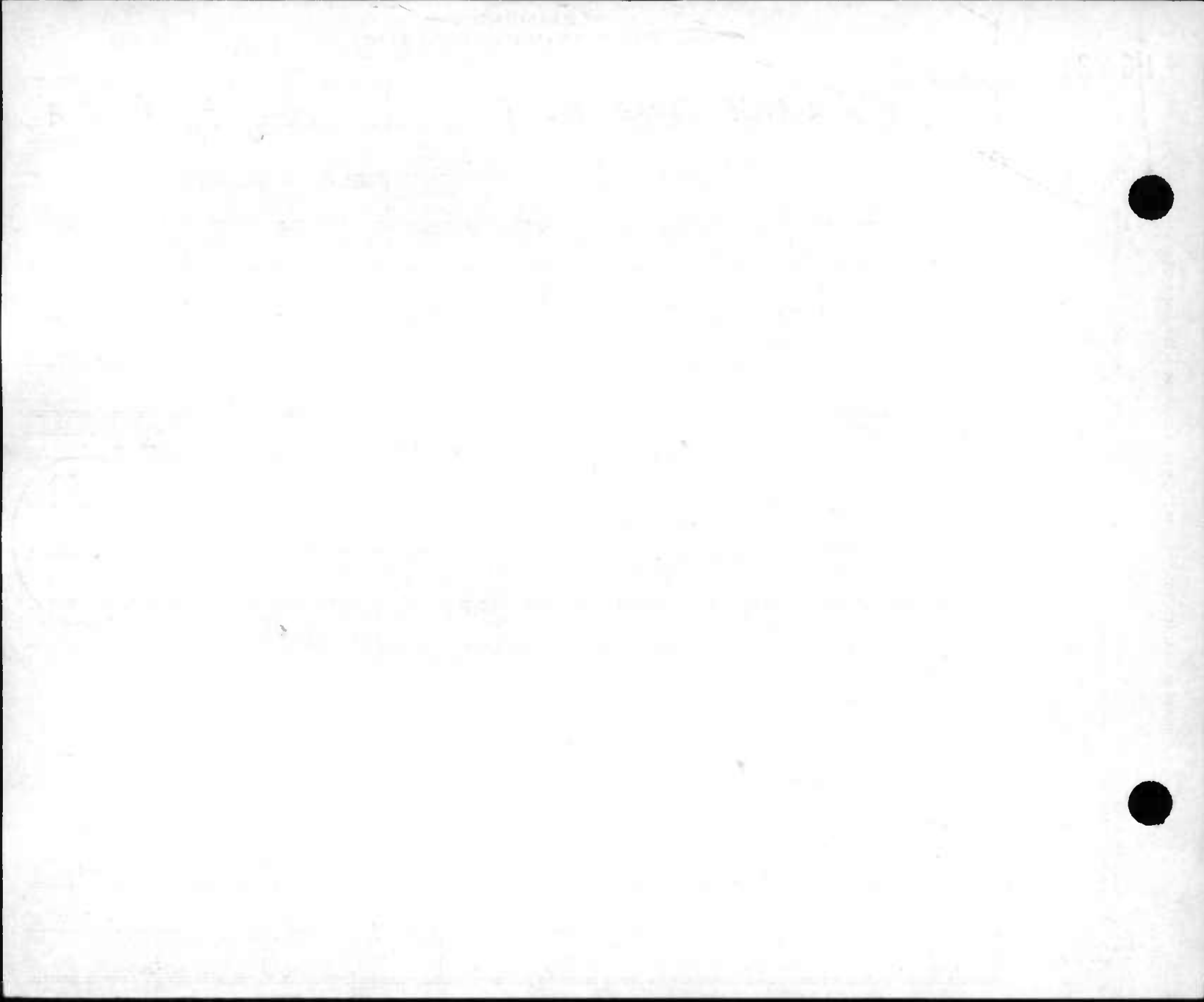
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP

DHMH-16 30M 2/80  
(VRA 15, 4)

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH									
1. FOR STATE REGISTRAR		2. DATE OF DEATH				3. HOUR			
1. DECEASED NAME (TYPE OR PRINT)		2. DATE OF DEATH				3. HOUR			
Catherine Flora Huff		Aug 25, 1986				9:30 A.M.			
4. SEX		5. RACE		6. DATE OF BIRTH		7. AGE		8. IF UNDER 1 YEAR	
female		white		July 25, 1905		81		IF UNDER 24 HRS.	
9. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		10. CITIZEN OF WHAT COUNTRY?		11. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		12. BALTIMORE CITY OR COUNTY OF DEATH		13. MD.	
Maryland		USA				Washington			
14. CITY OR TOWN OF DEATH		15. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		16. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		17. KIND OF BUSINESS OR INDUSTRY			
Hagerstown		Route 5		seamstress					
18. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)		19. STATE		20. COUNTY		21. CITY OR TOWN		22. INSIDE CITY LIMITS?	
Maryland		Washington		Hagerstown		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		23. STREET ADDRESS	
14. FATHER'S NAME		15. MOTHER'S MAIDEN NAME		16. ADDRESS		17. ADDRESS		18. ADDRESS	
Ralph S. Shank		Ethel Leiter		John F. Huff, Jr., Hagerstown, Md.					
19a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		19b. SOCIAL SECURITY NO.		19c. INFORMANT		19d. ADDRESS		19e. ADDRESS	
no		173-03-1967		John F. Huff, Jr., Hagerstown, Md.					
20. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)									
PART 1. DEATH WAS CAUSED BY:									
IMMEDIATE CAUSE (a) Multiple Myeloma									
DUE TO, OR AS A CONSEQUENCE OF									
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.									
(b)									
DUE TO, OR AS A CONSEQUENCE OF									
(c)									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)									
24a. DATE OF OPERATION		24b. CONDITION FOR WHICH OPERATION WAS PERFORMED				24c. AUTOPSY?		24d. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?	
						YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>	
25a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		25b. TIME OF INJURY		25c. HOW INJURY OCCURRED		(ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
		HOUR A.M. MONTH DAY YEAR							
25d. INJURY OCCURRED		25e. PLACE OF INJURY		25f. LOCATION		CITY OR TOWN		COUNTY STATE	
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		STREET					
26. I certify that (I) (this hospital) attended the deceased from 8-20-86 to 8-25-86, that (I) (we) saw the deceased alive on 8-20-86, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.									
27a. SIGNATURE		27b. DEGREE				27c. DATE SIGNED			
Charles R. Spencer		MD				8-25-86			
27d. PHYSICIAN'S NAME (TYPE OR PRINT)		27e. ADDRESS				27f. MEDICAL PHYSICIAN <input checked="" type="checkbox"/> DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			
Charles R. Spencer		1198 Kenly Ave Hagerstown Md.							
28a. BURIAL, CREMATION, REMOVAL (SPECIFY)		28b. DATE		28c. NAME OF CEMETERY OR CREMATORY		28d. LOCATION		COUNTY STATE	
burial		Aug. 28, 1986		Smithsburg Cemetery		Smithsburg, Wash., Maryland			
29. FUNERAL DIRECTOR		30. DATE REC'D. BY REGISTRAR				31. REGISTRAR'S SIGNATURE			
MINNICH FUNERAL HOME		AUG 27 1986							
415 E. Wilson Blvd., Hagerstown, Md. 21740									



0015875

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

86

24067  
REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <i>Samuel Otho Hull</i>			2a. DATE OF DEATH MONTH DAY YEAR August 6, 1986		2b. HOUR M
3. SEX male	4. RACE white	5. DATE OF BIRTH MONTH DAY YEAR August 18, 1887		6. AGE (IN YEARS LAST BIRTHDAY) 98 YRS.	IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland	7b. CITIZEN OF WHAT COUNTRY? USA	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Washington MD.	
10. CITY OR TOWN OF DEATH Hagerstown	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Washington County Hospital		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) engineer	12b. KIND OF BUSINESS OR INDUSTRY utility	
13a. STATE Maryland	13b. COUNTY Washington	13c. CITY OR TOWN Hagerstown	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>	13e. STREET ADDRESS / ZIP CODE 2108 Virginia Ave. 21740	
14. FATHER'S NAME FIRST MIDDLE LAST Otho S. Hull		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Anna Marie Houck			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No	(IF YES, GIVE WAR OR DATES)	16b. SOCIAL SECURITY NO. 214-10-4035	17. INFORMANT ADDRESS Theodore S. Hull, Hagerstown, Md.		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH CAUSED BY: IMMEDIATE CAUSE (a) <i>Coronary Heart Failure</i> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: (b) <i>Arteriosclerotic Heart Disease</i> DUE TO, OR AS A CONSEQUENCE OF (c) _____					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>10 days</i> <i>years</i>
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a) <i>Respiratory Failure, Chronic Obstructive Pulmonary Disease</i>					
19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from <i>8/5/86</i> to <i>8/6/86</i> , that (I) ( <del>was</del> ) lost saw the deceased alive on <i>8/5/86</i> , and that in (my) ( <del>own</del> ) opinion death occurred on the date and hour and from the causes stated above, (I) ( <del>was</del> ) ( <del>did not</del> ) view the body after death.					
22b. SIGNATURE <i>Edmund H. ...</i>		DEGREE <i>MD</i>	ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>	22c. DATE SIGNED <i>8/7/86</i>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT)		22e. ADDRESS			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) burial	23b. DATE Aug. 9, 1986	23c. NAME OF CEMETERY OR CREMATORY Rest Haven Cemetery	23d. LOCATION CITY OR TOWN COUNTY STATE Hagerstown, Wash., Maryland		
24. FUNERAL DIRECTOR NAME MINNICH FUNERAL HOME 415 E. Wilson Blvd., Hagerstown, Md. 21740			25. DATE REC'D BY REGISTRAR AUG 12 1986 J. ...		

MEDICAL CERTIFICATION

25-79-35-211

2

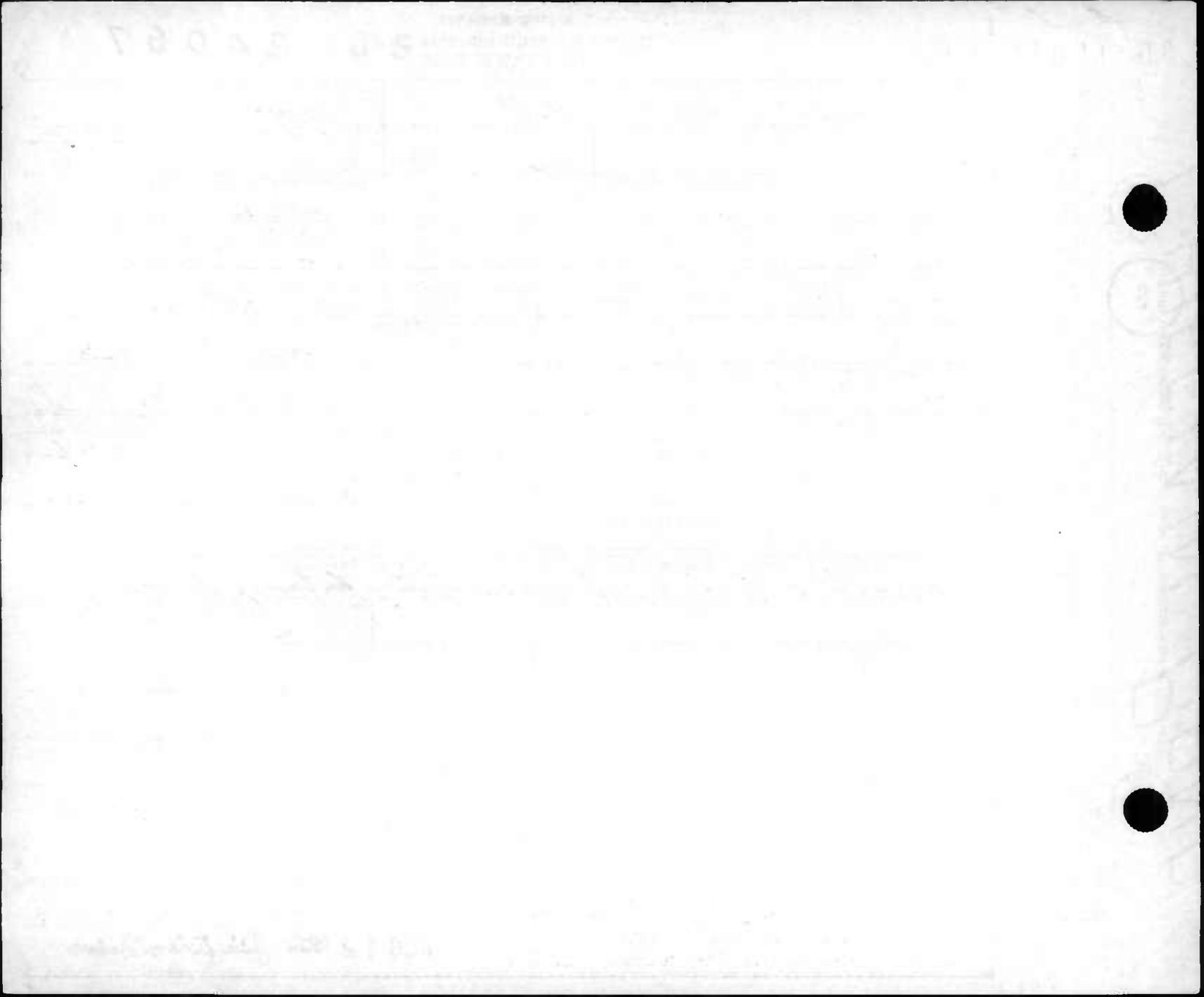
DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

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TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP



00-15214

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING "PENDING" IN PENCIL IN ITEM 18. GIVE FORMS 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORMS 1, 2, AND 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED AND RETURNED TO THE DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

24068  
REG. NO.1- FOR  
STATE  
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) <b>Franklin Victor Jones</b> <b>FRANKLIN VICTOR JONES</b>				2a. DATE KNOWN OF DEATH ESTIMATED <input checked="" type="checkbox"/> MONTH DAY YEAR 8-7 19 86				2b. HOUR 3:30 PM	
3. SEX <b>Male</b>	4. RACE <b>White</b>	5. DATE OF BIRTH MONTH DAY YEAR <b>June 18, 1916</b>	6. AGE (IN YEARS) (LAST BIRTHDAY) MONTHS DAYS HOURS MIN. <b>70 YRS.</b>	IF UNDER 1 YR.	IF UNDER 24 HRS.	7c. DATE PRONOUNCED DEAD 8-7 19 86	7d. HOUR 6:00 AM		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Maryland</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>WASHINGTON MD.</b>			
10. CITY OR TOWN OF DEATH <b>Hagerstown</b>		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Washington County Hospital</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Laborer</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>Door Co.</b>	
13a. STATE <b>Maryland</b>				13b. COUNTY <b>Washington</b>	13c. CITY OR TOWN <b>Hagerstown</b>	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> 13e. STREET ADDRESS <b>334 Mitchell Avenue</b>			
14. FATHER'S NAME FIRST MIDDLE LAST <b>Oscar Jones</b>				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Annie M. Troupe</b>				16. ADDRESS <b>Hagerstown, Md.</b>	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) <b>No</b>		16b. SOCIAL SECURITY NO. <b>214-16-1967</b>		17. INFORMANT <b>Madaline E. Jones 334 Mitchell Ave.</b>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>CARDIAC ARRHYTHMIA (ARREST) #427</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. (b) <b>CONGESTIVE HEART FAILURE C PVC #428</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>CHRONIC OBSTRUCTIVE PULMONARY DISEASE #496</b>									
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I <b>CHRONIC OBSTRUCTIVE PULMONARY DISEASE #496</b>									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?					20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that I took charge of the remains described above, held on death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion									
ACTUAL SIGNATURE <b>George Milic</b>		TITLE (SPECIFY) <b>DEPUTY</b>		MEDICAL EXAMINER <b>40 MANOR DR #103</b>		DATE SIGNED <b>8-7-86</b>			
EXAMINER'S NAME (TYPE OR PRINT) <b>GEORGE MILIC, MD</b>		ADDRESS <b>HAGERSTOWN - MD - 21740</b>							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>7-11-86</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Broadfording Cemetery Hagerstown, Washington, Md.</b>			23d. LOCATION CITY OR TOWN COUNTY STATE		
24. FUNERAL DIRECTOR NAME <b>A.K. Coffman Funeral Home, Inc.</b>		ADDRESS <b>Hagerstown, Md.</b>		25a. DATE RECEIVED BY REGISTRAR <b>AUG 14 1986</b>		25b. REGISTRAR'S SIGNATURE			

07/84  
25M

BP

DHMH - 17  
(VR A15 ME (5))

100-1111

Franklin Victor Jones  
Victor Jones

June 18, 1916 to

U.S.A.

England

Washington County Hospital as over

Washington County Hospital

Apple

Worcester

Worcester

Worcester, Mass.  
Worcester

1911-1912 Washington County Hospital as over

Washington County Hospital as over

Washington County Hospital as over

1911-1912

Washington County Hospital as over

Washington County Hospital as over

Washington County Hospital as over

Washington County Hospital as over

A. W. Jones & Sons, Inc.

00-14238

Item # 2a, Film 6 62 0 10/22/86 ra

1 - STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

24069

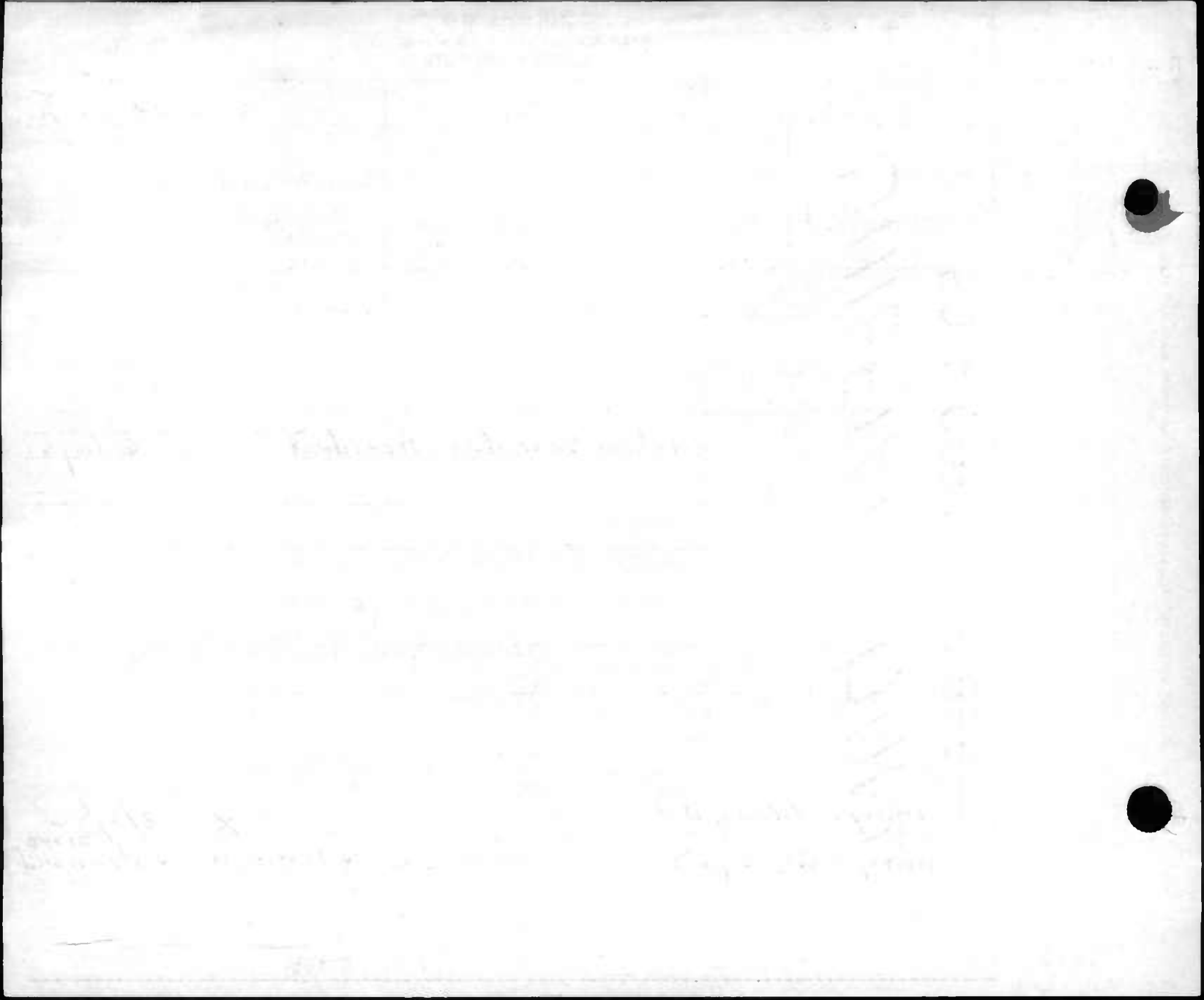
1. DECEASED NAME (TYPE OR PRINT) <b>George Dewey Kaetzel</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>8 2 84</b>		2b. HOUR <b>12<sup>05</sup> AM</b>
3. SEX <b>Male</b>	4. RACE <b>White</b>	5. DATE OF BIRTH MONTH DAY YEAR <b>Dec. 5, 1900</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>85</b> YRS.	IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Pennsylvania</b>	7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Washington County</b> MD.	
10. CITY OR TOWN OF DEATH <b>Hagerstown</b>	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Washington County Hospital</b>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Farmer</b>		12b. KIND OF BUSINESS OR INDUSTRY
13a. STATE <b>Maryland</b>		13b. COUNTY <b>Washington</b>	13c. CITY OR TOWN <b>Hagerstown</b>	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>Charles Edward Kaetzel</b>		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Fannie Mae Hershberger</b>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>No</b>		16b. SOCIAL SECURITY NO. <b>217-28-1175</b>		17. INFORMANT ADDRESS <b>Lillian D. Bingaman Route # 2 Hancock, Md.</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebral Vascular Accident</b>					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>6 days.</b>
DUE TO, OR AS A CONSEQUENCE OF (b) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. DUE TO, OR AS A CONSEQUENCE OF (c) _____					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) lost saw the deceased alive on _____, 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE <b>Mary E. Money MD</b>		DEGREE		22c. DATE SIGNED <b>8/2/84</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>Mary E. Money MD</b>		22e. ADDRESS <b>1708 Oak Hill Ave, Hagerstown, Md 21740</b>			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>8-5-86</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Broadfording Cemetery</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Hagerstown, Washington, Md.</b>
24. FUNERAL DIRECTOR NAME <b>Donald E. Thompson Funeral Home, Inc.</b>		ADDRESS <b>Clear Spring, Md.</b>		25a. DATE REC'D. BY REGISTRAR <b>AUG 4 1986</b>	
				25b. REGISTRAR'S SIGNATURE <b>Juan Davidson-Randall</b>	

BP \_\_\_\_\_

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, Pages 1 and 2 and return them filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked at item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.





00-15962

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PW 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL TRANSFER PERMIT. PAGES 4 AND 5 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH. WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

24070

1- FOR  
STATE  
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT)			2b. DATE KNOWN OF DEATH			2c. DATE OF ESTI- MATED DEATH			2d. HOUR		
JOSIE SARAH KELLER			Aug. 15 86			19			6:40P		
3. SEX	4. RACE	5. DATE OF BIRTH	6. AGE (IN YEARS)	IF UNDER 1 YR.	IF UNDER 24 HRS.	2e. DATE OF PRONOUNCE- DEAD			2f. HOUR		
Female	White	Nov. 2 1889	96 YRS.			Aug. 15 86			6:40P		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)			7b. CITIZEN OF WHAT COUNTRY?			8. MARRIED			9. BALTIMORE CITY OR COUNTY OF DEATH		
Maryland			U.S.A.			WIDOWED			WASHINGTON MD.		
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY		
Hagerstown			Washington County Hospital			Farmer			Farm		
13a. USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)			13b. INSIDE CITY LIMITS?			13c. STREET ADDRESS					
Maryland			YES			4 Poplar Street/21773					
14. FATHER'S NAME			15. MOTHER'S MAIDEN NAME								
H. Melvin Keller			Helen Sarah Schildtnecht								
16a. WAS DECEASED EVER IN U.S. ARMED FORCES?			16b. SOCIAL SECURITY NO.			17. INFORMANT			19 Main Street		
No			212-50-7655			Claude Keller			Myersville, MD 21773		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
PART I DEATH WAS CAUSED BY:									428		
IMMEDIATE CAUSE (a) CONJESTIVE HEART FAILURE									ONE WEEK		
DUE TO, OR AS A CONSEQUENCE OF									429		
(b) ADVANCED ARTERIOSCLEROTIC HEART DISEASE									MANY YEARS		
DUE TO, OR AS A CONSEQUENCE OF											
(c)											
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I											
SUBCAPITAL FRACTURE OF RIGHT HIP N821											
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?						20. AUTOPSY?		
JULY 3 1986			OPEN REDUCTION AND INSERTION OF ENDOPROSTHESIS						YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH			21b. TIME OF INJURY			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)					
12:30P JUNE 27 86			FELL OUT OF BED AT FAHRNEY-KEEDY HOME								
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)			21f. LOCATION			CITY OR TOWN		
NURSING HOME			ROUTE #2 Box 78			BOONSBORO			WASH. MD.		
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> .											
ACTUAL SIGNATURE			TITLE (SPECIFY)			DATE SIGNED					
Edward W. Ditto			M.D. DEPUTY			MEDICAL EXAMINER			Aug 15, 1986		
EXAMINER'S NAME (TYPE OR PRINT)			ADDRESS								
EDWARD W. DITTO 111 MD			217 W. WASHINGTON STREET, HAGERSTOWN, MD								
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)			23b. DATE			23c. NAME OF CEMETERY OR CREMATORY			23d. LOCATION		
Burial			8-18-86			Mt. Zion U. Methodist Cem.			Myersville Frederick Maryland		
24. FUNERAL DIRECTOR			ADDRESS			25a. DATE REC'D. BY REGISTRAR			25b. REGISTRAR'S SIGNATURE		
Ricketts Funeral Home			Myersville, MD 21773			AUG 20 1986			John Davidson-Ricketts		

07-184  
25MDHMH - 17  
(VR A15 ME (5))

4000 0 1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18 19 20 21 22 23 24 25 26 27 28 29 30 31 32 33 34 35 36 37 38 39 40 41 42 43 44 45 46 47 48 49 50 51 52 53 54 55 56 57 58 59 60 61 62 63 64 65 66 67 68 69 70 71 72 73 74 75 76 77 78 79 80 81 82 83 84 85 86 87 88 89 90 91 92 93 94 95 96 97 98 99 100 101 102 103 104 105 106 107 108 109 110 111 112 113 114 115 116 117 118 119 120 121 122 123 124 125 126 127 128 129 130 131 132 133 134 135 136 137 138 139 140 141 142 143 144 145 146 147 148 149 150 151 152 153 154 155 156 157 158 159 160 161 162 163 164 165 166 167 168 169 170 171 172 173 174 175 176 177 178 179 180 181 182 183 184 185 186 187 188 189 190 191 192 193 194 195 196 197 198 199 200 201 202 203 204 205 206 207 208 209 210 211 212 213 214 215 216 217 218 219 220 221 222 223 224 225 226 227 228 229 230 231 232 233 234 235 236 237 238 239 240 241 242 243 244 245 246 247 248 249 250 251 252 253 254 255 256 257 258 259 260 261 262 263 264 265 266 267 268 269 270 271 272 273 274 275 276 277 278 279 280 281 282 283 284 285 286 287 288 289 290 291 292 293 294 295 296 297 298 299 300 301 302 303 304 305 306 307 308 309 310 311 312 313 314 315 316 317 318 319 320 321 322 323 324 325 326 327 328 329 330 331 332 333 334 335 336 337 338 339 340 341 342 343 344 345 346 347 348 349 350 351 352 353 354 355 356 357 358 359 360 361 362 363 364 365 366 367 368 369 370 371 372 373 374 375 376 377 378 379 380 381 382 383 384 385 386 387 388 389 390 391 392 393 394 395 396 397 398 399 400 401 402 403 404 405 406 407 408 409 410 411 412 413 414 415 416 417 418 419 420 421 422 423 424 425 426 427 428 429 430 431 432 433 434 435 436 437 438 439 440 441 442 443 444 445 446 447 448 449 450 451 452 453 454 455 456 457 458 459 460 461 462 463 464 465 466 467 468 469 470 471 472 473 474 475 476 477 478 479 480 481 482 483 484 485 486 487 488 489 490 491 492 493 494 495 496 497 498 499 500 501 502 503 504 505 506 507 508 509 510 511 512 513 514 515 516 517 518 519 520 521 522 523 524 525 526 527 528 529 530 531 532 533 534 535 536 537 538 539 540 541 542 543 544 545 546 547 548 549 550 551 552 553 554 555 556 557 558 559 560 561 562 563 564 565 566 567 568 569 570 571 572 573 574 575 576 577 578 579 580 581 582 583 584 585 586 587 588 589 590 591 592 593 594 595 596 597 598 599 600 601 602 603 604 605 606 607 608 609 610 611 612 613 614 615 616 617 618 619 620 621 622 623 624 625 626 627 628 629 630 631 632 633 634 635 636 637 638 639 640 641 642 643 644 645 646 647 648 649 650 651 652 653 654 655 656 657 658 659 660 661 662 663 664 665 666 667 668 669 670 671 672 673 674 675 676 677 678 679 680 681 682 683 684 685 686 687 688 689 690 691 692 693 694 695 696 697 698 699 700 701 702 703 704 705 706 707 708 709 710 711 712 713 714 715 716 717 718 719 720 721 722 723 724 725 726 727 728 729 730 731 732 733 734 735 736 737 738 739 740 741 742 743 744 745 746 747 748 749 750 751 752 753 754 755 756 757 758 759 760 761 762 763 764 765 766 767 768 769 770 771 772 773 774 775 776 777 778 779 780 781 782 783 784 785 786 787 788 789 790 791 792 793 794 795 796 797 798 799 800 801 802 803 804 805 806 807 808 809 810 811 812 813 814 815 816 817 818 819 820 821 822 823 824 825 826 827 828 829 830 831 832 833 834 835 836 837 838 839 840 841 842 843 844 845 846 847 848 849 850 851 852 853 854 855 856 857 858 859 860 861 862 863 864 865 866 867 868 869 870 871 872 873 874 875 876 877 878 879 880 881 882 883 884 885 886 887 888 889 890 891 892 893 894 895 896 897 898 899 900 901 902 903 904 905 906 907 908 909 910 911 912 913 914 915 916 917 918 919 920 921 922 923 924 925 926 927 928 929 930 931 932 933 934 935 936 937 938 939 940 941 942 943 944 945 946 947 948 949 950 951 952 953 954 955 956 957 958 959 960 961 962 963 964 965 966 967 968 969 970 971 972 973 974 975 976 977 978 979 980 981 982 983 984 985 986 987 988 989 990 991 992 993 994 995 996 997 998 999 1000 1001 1002 1003 1004 1005 1006 1007 1008 1009 1010 1011 1012 1013 1014 1015 1016 1017 1018 1019 1020 1021 1022 1023 1024 1025 1026 1027 1028 1029 1030 1031 1032 1033 1034 1035 1036 1037 1038 1039

00-15353

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1- FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

24071

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Mary Katherine KING			2a. DATE OF DEATH MONTH DAY YEAR August 8, 1986		2b. HOUR 10:00 A.M.		
3. SEX female		4. RACE white		5. DATE OF BIRTH MONTH DAY YEAR October 20, 1904		6. AGE (IN YEARS LAST BIRTHDAY) 81 YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Washington MD.	
10. CITY OR TOWN OF DEATH Hagerstown		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Route 10 Trovinger Mill Road		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) housewife		12b. KIND OF BUSINESS OR INDUSTRY	
13a. STATE Maryland		13b. COUNTY Washington		13c. CITY OR TOWN Hagerstown		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST Newton Gaines		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Ada Manning		13e. STREET ADDRESS / ZIP CODE Route 10, Box 79 Trovinger Mill Rd. 21740			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 820-02-4477		17. INFORMANT Mrs. Wanda Mertz, Hagerstown, Maryland		ADDRESS	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Blood Clots with Cerebral</u> DUE TO, OR AS A CONSEQUENCE OF <u>metastases with</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) <u>Terminal Stroke</u> DUE TO, OR AS A CONSEQUENCE OF (c)						APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 10 years	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (1) this hospital attended the deceased from <u>July 28</u> 19 <u>86</u> to <u>Aug 8</u> 19 <u>86</u> that (1) (we) last saw the deceased on <u>Aug 8</u> 19 <u>86</u> and that in my (our) opinion death occurred on the date and hour and from the causes stated above.							
22b. SIGNATURE <u>Robert Brull</u>		DEGREE MD		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 8/11/86	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Robert Brull MD		22e. ADDRESS 1459 Potomac Ave Hagerstown MD					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) burial		23b. DATE Aug. 11, 1986		23c. NAME OF CEMETERY OR CREMATORY Cedar Lawn Mem. Park		23d. LOCATION CITY OR TOWN COUNTY STATE Hagerstown, Wash., Maryland	
24. FUNERAL DIRECTOR NAME 415 E. Wilson Blvd., Hagerstown, Maryland 21740				25a. DATE REC'D. BY REGISTRAR AUG 13 1986		25b. REGISTRAR'S SIGNATURE <u>J. Davidson</u>	

2025 COTTON LITE

1 - FOR  
STATE  
REGISTRAR

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

24072  
REG. NO.

0-16220

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <b>MARGARET VIRGINIA KRETSINGER</b>				2a. DATE OF DEATH MONTH DAY YEAR <b>AUGUST 11, 1986</b>		2b. HOUR M <b>M</b>	
3. SEX <b>FEMALE</b>		4. RACE <b>WHITE</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>AUGUST 2, 1905</b>		6. AGE (IN YEARS LAST BIRTHDAY) YRS. MONTHS DAYS <b>81</b>	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>MARYLAND</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>WASHINGTON</b> MD.	
10. CITY OR TOWN OF DEATH <b>HAGERSTOWN</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>WASHINGTON COUNTY HOSPITAL</b>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>HOUSEWORK</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>HOUSEWIFE</b>	
13a. STATE <b>MARYLAND</b>		13b. COUNTY <b>WASHINGTON</b>		13c. CITY OR TOWN <b>WILLIAMSPORT</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>PORTERFIELD - DAYNE</b>		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>CECELIA ARDINGER PAYNE</b>		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) <b>NO NO</b>		16b. SOCIAL SECURITY NO. <b>217-09-8278</b>	
17. INFORMANT NAME ADDRESS <b>KATY O CONNELL 151 N. ARTIZAN ST.</b>		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Perforated sigmoid colon with bowel abscesses</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>Stomach treatment for temporal arteritis</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b></b>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>18 days</b>			
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a:							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE <b>Mary E. Money</b>				DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		22c. DATE SIGNED <b>8/12/86</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>Mary E. Money MD.</b>				22e. ADDRESS <b>1708 Oak Hill Ave, Hagerstown, MD 21740</b>			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>BURIAL</b>		23b. DATE <b>AUG. 13, 1986</b>		23c. NAME OF CEMETERY OR CREMATORY <b>RIVERVIEW CEMETERY</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>WILLIAMSPORT/WASHINGTON MD</b>	
24. FUNERAL DIRECTOR NAME ADDRESS <b>MAYOR M. OSBORNE P.O. BOX 348 WILLIAMSPORT, MD 21795</b>				25a. DATE REC'D. BY REGISTRAR <b>Aug 30 1986</b>		25b. REGISTRAR'S SIGNATURE	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove section pages. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or other disposition.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP

17

1. The first part of the document is a letter from the President of the United States to the Congress, dated January 1, 1801.

2. The second part is a report from the Secretary of the Navy, dated January 1, 1801.

3. The third part is a report from the Secretary of the Treasury, dated January 1, 1801.

4. The fourth part is a report from the Secretary of the War, dated January 1, 1801.

5. The fifth part is a report from the Secretary of the Interior, dated January 1, 1801.

6. The sixth part is a report from the Secretary of the State, dated January 1, 1801.

7. The seventh part is a report from the Secretary of the War, dated January 1, 1801.

8. The eighth part is a report from the Secretary of the Navy, dated January 1, 1801.

9. The ninth part is a report from the Secretary of the Treasury, dated January 1, 1801.

10. The tenth part is a report from the Secretary of the State, dated January 1, 1801.

15046

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO. 24073

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <b>Frederick Luther Leatherman</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>8 2 86</b>		2b. HOUR <b>1:00 PM</b>		
3. SEX <b>M</b>		4. RACE <b>Cau</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>3 7 14</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>72</b> YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN) <b>Sharpsburg, Md.</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Washington</b> MD.	
10. CITY OR TOWN OF DEATH <b>Hagerstown</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Washington County Hosp</b>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Metal Worker.</b>		12b. KIND OF BUSINESS OR INDUSTRY	
13a. STATE <b>Md.</b>		13b. COUNTY <b>Wash</b>		13c. CITY OR TOWN <b>Hagerstown</b>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>Alvey C. Leatherman</b>		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Golden Blanche Gray</b>		13e. STREET ADDRESS / ZIP CODE <b>Collins Hwy Hare 21740</b>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <input type="checkbox"/> IF YES, GIVE WAR OR DATES <b>No</b>		16b. SOCIAL SECURITY NO. <b>213-12-1052</b>		17. INFORMANT ADDRESS <b>Mrs. Mabel R. Mumma, Sharpsburg, Md. 21782</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cadain anet.</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Alzheim</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>cardiac failure</b>						APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)							
19a. DATE OF OPERATION <b>7/16</b>		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED <b>gastro 3 feet</b>		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from <b>7/15/86</b> , 19 <b>86</b> , to <b>8/2</b> , 19 <b>86</b> , that (I) (we) lost saw the deceased alive on <b>8/2</b> , 19 <b>86</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE <b>Gerald Scallan</b>				DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		22c. DATE SIGNED <b>8/3/86</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>Dr. Gerald Scallan</b>				22e. ADDRESS <b>645 E. First St. Hagerstown Md.</b>			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>August 5, 1986</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Mt. View Cemetery</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Sharpsburg Washington Md.</b>	
24. FUNERAL DIRECTOR NAME ADDRESS <b>Bast Funeral Home Boonsboro, Maryland 21713</b>				25a. DATE REC'D. BY REGISTRAR <b>AUG 05 1986</b>		25b. REGISTRAR'S SIGNATURE <b>Julie Jackson-Randall</b>	

MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial transit permit. Then please remove carbon papers. Pages 4 and 5 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked as item 1B shows any injury, or other traumatic event, the medical examiner must be notified at once.

*[The page contains extremely faint, illegible text, likely bleed-through from the reverse side. The text is arranged in several paragraphs and is not readable.]*



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DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

1- FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

24074

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <i>Elmer William Long, Sr.</i>			2a. DATE OF DEATH MONTH DAY YEAR <i>8 17 86</i>		2b. HOUR <i>255 AM</i>
1. SEX <i>male</i>	4. RACE <i>white</i>	5. DATE OF BIRTH MONTH DAY YEAR <i>March 20, 1933</i>		6. AGE (IN YEARS LAST BIRTHDAY) <i>53</i> YRS.	IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <i>Maryland</i>	7b. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH <i>Washington</i> MD.		
10. CITY OR TOWN OF DEATH <i>Hagerstown</i>	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <i>Washington County Hospital</i>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <i>truck driver</i>	12b. KIND OF BUSINESS OR INDUSTRY <i>insulation Co.</i>	
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE <i>Maryland</i>			13b. COUNTY <i>Washington</i>	13c. CITY OR TOWN <i>Hagerstown</i>	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
13e. STREET ADDRESS / ZIP CODE <i>Route 4, Box 65B 21740</i>					
14. FATHER'S NAME FIRST MIDDLE LAST <i>David Elmer Long</i>		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <i>Edna Mae Fletcher</i>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <i>yes</i>	16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) <i>1953-1959</i>	17. INFORMANT ADDRESS <i>Mrs. Mary L. Long, Hagerstown, Maryland</i>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Carcinoma of Lung.</i> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>Smoking</i> DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>5 Mo.</i>					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)					
19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <i>P.M. 19</i>	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1B PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from <i>June 8, 1982</i> , to <i>8</i> , 19 <i>86</i> , that (I) <del>most</del> last saw the deceased alive on <i>8/14</i> , 19 <i>86</i> , and that in (my) <del>last</del> opinion death occurred on the date and hour and from the causes stated above, (I) <del>was</del> <i>did</i> not view the body after death.					
22b. SIGNATURE <i>Mary E. Money</i>		DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED <i>8/17/86</i>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <i>Mary E. Money</i>		22e. ADDRESS <i>1708 Oak Hill Ave, Hagerstown, Md.</i>			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>burial</i>	23b. DATE <i>Aug. 20, 1986</i>	23c. NAME OF CEMETERY OR CREMATORY <i>Cedar Lawn Mem. Park</i>	23d. LOCATION CITY OR TOWN COUNTY STATE <i>Hagerstown, Wash., Maryland</i>		
24. FUNERAL DIRECTOR NAME ADDRESS <i>MINNICH FUNERAL HOME 415 E. Wilson Blvd., Hagerstown, Maryland 21740</i>		25a. DATE REC'D. BY REGISTRAR <i>AUG 19 1986</i>		25b. REGISTRAR'S SIGNATURE <i>Jana Davidson-Robert</i>	

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1- FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH24075  
REG. NO.

1. DECEASED NAME (TYPE OR PRINT) <b>LUGRETTA ELLEN MARSHALL</b> <i>Lugretta Ellen Marshall</i>				2a. DATE OF DEATH MONTH DAY YEAR <b>8 18 86</b>				2b. HOUR <b>1:13 P.M.</b>	
3. SEX <b>FEMALE</b>		4. RACE <b>White</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>3-25-29</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>57</b>		7. IF UNDER 1 YEAR IF UNDER 24 HRS. MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Hagerstown</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>WASHINGTON COUNTY MD.</b>			
10. CITY OR TOWN OF DEATH <b>Hagerstown</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>WASHINGTON COUNTY HOSPITAL</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY	
13a. STATE <b>MARYLAND</b>		13b. COUNTY <b>WASHINGTON</b>		13c. CITY OR TOWN <b>FUNKSTOWN</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE <b>P.O. Box 373 Funkstown 21734</b>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>Elmer Locke Smith</b>				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Effie Viola Hornbaker</b>					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>No</b>		16b. SOCIAL SECURITY NO. <b>---</b>		17. INFORMANT ADDRESS <b>Box 373 Carroll S. Marshall Sr., Funkstown, Md.</b>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cardiorespiratory Arrest</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>Malignant Lymphoma</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>5 months</b>									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a):									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from <b>8/18/86</b> to <b>8/19/86</b> , that (I) (we) last saw the deceased alive on <b>8/18/86</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE <i>Frederic H. Koss</i>				DEGREE <b>MD</b>				22c. DATE SIGNED <b>8/19/86</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>Frederic H. Koss</b>				22e. ADDRESS <b>1825 Howell Rd Hagerstown, Md.</b>					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>8-21-86</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Rose Hill Cemetery</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Hagerstown, Washington, Md.</b>			
24. FUNERAL DIRECTOR NAME <b>A.K. Coffman Funeral Home, Inc.</b>				25a. DATE REC'D. BY REGISTRAR <b>AUG 22 1986</b>		25b. REGISTRAR'S SIGNATURE <i>John Davidson</i>			

MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove copies of pages 1 and 2 and send them to the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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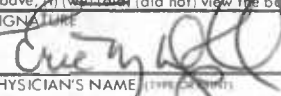

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1- FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO. 24076

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <b>MARTHA Ellen MARTIN</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>August 27 1986</b>		2b. HOUR M <b>M</b>
3. SEX <b>Female</b>	4. RACE <b>White</b>	5. DATE OF BIRTH MONTH DAY YEAR <b>March 4 1913</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>73</b> YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Maryland</b>	7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Washington</b> MD.	
10. CITY OR TOWN OF DEATH <b>Hagerstown</b>	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Washington County Hospital</b>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Housewife</b>		12b. KIND OF BUSINESS OR INDUSTRY
13a. STATE <b>Maryland</b>	13b. COUNTY <b>Washington</b>	13c. CITY OR TOWN <b>Hagerstown</b>	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	13e. STREET ADDRESS / ZIP CODE <b>2206 Ontario Drive</b> <b>21740</b>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>David P. Bowers</b>		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Hattie L. Skelton</b>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>No</b>		16b. SOCIAL SECURITY NO. <b>218-38-0920</b>		17. INFORMANT ADDRESS <b>Gerald Holmes Hagerstown, Maryland 21740</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Atherosclerotic Cardiovascular Disease</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: (b) <b>Diabetes Mellitus</b> DUE TO, OR AS A CONSEQUENCE OF (c)					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from <b>4-4</b> , 19 <b>80</b> , to <b>8-4</b> , 19 <b>86</b> , that (I) (we) last saw the deceased alive on <b>8-4</b> , 19 <b>86</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (If we) (did not) view the body after death.					
22b. SIGNATURE 		DEGREE <b>MD</b>		22c. DATE SIGNED <b>8-28-86</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>Eric W. Wagshal</b>		22e. ADDRESS <b>1825 Howell Rd. Hagerstown Maryland 21740</b>			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>	23b. DATE <b>8-30-86</b>	23c. NAME OF CEMETERY OR CREMATORY <b>GreenLawn Mem. Park</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Willamsport Washington Md.</b>	
24. FUNERAL DIRECTOR NAME <b>Bast Funeral Home</b>		ADDRESS <b>Boonsboro, Maryland 21713</b>		25a. DATE REC'D. BY REGISTRAR <b>SEP 2 1986</b>	25b. REGISTRAR'S SIGNATURE 

BP

DHMH - 16 60M 7/84  
(VRA 15, 4)

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 22 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 8 shows any injury, or other traumatic event, the medical examiner must be notified.

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DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use on the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

DHMH 16-60M 7/84  
(VRA 15.4)

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

6 6

REG. NO. 24077

1. FOR  
STATE  
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <i>Harold DONALD MCCOY</i>			2a. DATE OF DEATH MONTH DAY YEAR <i>8 21 86</i>		2b. HOUR <i>11.47</i> M
3. SEX <i>Male</i>	4. RACE <i>White</i>	5. DATE OF BIRTH MONTH DAY YEAR <i>May 25, 1911</i>		6. AGE (IN YEARS LAST BIRTHDAY) <i>75</i> YRS.	IF UNDER 1 YEAR MONTHS DAYS IF UNDER 1 YRS HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <i>Pennsylvania</i>	7b. CITIZEN OF WHAT COUNTRY? <i>USA.</i>	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <i>Washington</i> MD.	
10. CITY OR TOWN OF DEATH <i>Hagerstown</i>	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <i>Washington County Hospital</i>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <i>Engineer</i>	12b. KIND OF BUSINESS OR INDUSTRY <i>Manufacturing</i>	
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE <i>W. Va.</i>	13b. COUNTY <i>Morgan</i>	13c. CITY OR TOWN <i>Berkley Springs</i>	13d. INSIDE CITY LIMITS? <input type="checkbox"/> NO <input checked="" type="checkbox"/>	13e. STREET ADDRESS / ZIP CODE <i>P.O. Box 415 25422</i>	
14. FATHER'S NAME FIRST MIDDLE LAST <i>Unknown</i>		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <i>Unknown</i>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <i>Yes</i>		16b. SOCIAL SECURITY NO. <i>215-10-5220</i>		17. INFORMANT ADDRESS <i>3308 View Ridge Court Manchester, Md. 21102</i>	
18. CAUSE OF DEATH (Enter only one cause per line (a), (b) and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Acute myocardial infarction</i> DUE TO, OR AS A CONSEQUENCE OF (b) <i>subacute heart Cardiovascular Disease</i> DUE TO, OR AS A CONSEQUENCE OF (c) <i></i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>3 days</i> <i>years</i>
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a): <i>Diabetes Mellitus</i>					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <i>P.M. 19</i>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from <i>Apr. 1</i> 19 <i>86</i> to <i>Aug 21</i> 19 <i>86</i> , that (I) (we) lost saw the deceased alive on <i>Aug 21</i> 19 <i>86</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) <i>sign the body after death.</i>					
22b. SIGNATURE <i>C. S. A.</i>		DEGREE <i>MD</i>		22c. DATE SIGNED	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <i>C. S. A.</i>		22e. ADDRESS <i>201 S. Calverland Ave. Hagerstown Md</i>			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>Cremation</i>		23b. DATE <i>8/23/86</i>	23c. NAME OF CEMETERY OR CREMATORY <i>Westview Mem. Park Baltimore, Baltimore Md</i>		23d. LOCATION CITY OR TOWN COUNTY STATE
24. FUNERAL DIRECTOR NAME <i>R. Long Heston</i>		24b. ADDRESS <i>Eckhardt Funeral Chapel Manchester, Md. 21102</i>		25. DATE REC'D. BY REGISTRAR <i>AUG 22 1986</i>	

MEDICAL CERTIFICATION

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00-17688

1- FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 6 2 4 0 7 8

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <b>Alice Nancy Miller</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>August 16 1986</b>		2b. HOUR M <b>M</b>
3. SEX <b>Female</b>	4. RACE <b>White</b>	5. DATE OF BIRTH MONTH DAY YEAR <b>Jan. 19 1896</b>		6. AGE (IN YEARS LAST BIRTHDAY) YRS <b>90</b>	IF UNDER 1 YEAR MONTHS DAYS <b>0 0</b>
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Maryland</b>	7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Washington County</b> MD.	
10. CITY OR TOWN OF DEATH <b>Hagerstown</b>	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>108 East North Avenue</b>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Homemaker</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>Home</b>
13a. STATE <b>Maryland</b>	13b. COUNTY <b>Washington</b>	13c. CITY OR TOWN <b>Hagerstown</b>	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET ADDRESS / ZIP CODE <b>108 East North Avenue 21740</b>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>Charles Wesley Hartle</b>		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Coralinda Spessard</b>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>No</b>		16b. SOCIAL SECURITY NO. <b>213-74-2830</b>		17. INFORMANT ADDRESS <b>Jean L. Miller same as 13</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebro-Vascular Accident (Thrombosis)</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Arteriosclerotic Cerebro-Vascular Disease</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>Arteriosclerosis, generalized</b> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (c)					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1b. PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from <b>6-4-86</b> , 19____, to <b>8-16-86</b> , 19____, that (I) (we) lost saw the deceased alive on <b>8-16-86</b> , 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above; (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE <b>W. M. Fender</b>		DEGREE <b>MD</b>		22c. DATE SIGNED	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>W. M. Fender</b>		22e. ADDRESS <b>138 E. Antietam St. Hagerstown MD 21740</b>			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Cremation</b>	23b. DATE <b>8-18-86</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Smithsburg Crematory</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Smithsburg Wash. Md.</b>	
24. FUNERAL DIRECTOR NAME <b>Gerald N. Minnich</b>		25a. DATE REC'D. BY REGISTRAR <b>AUG 27 1986</b>		25b. REGISTRAR'S SIGNATURE <b>J. A. Davidson</b>	

MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, it must be filed in by the funeral director. Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked 0, the medical examiner must be notified.

BP \_\_\_\_\_



00-16406

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

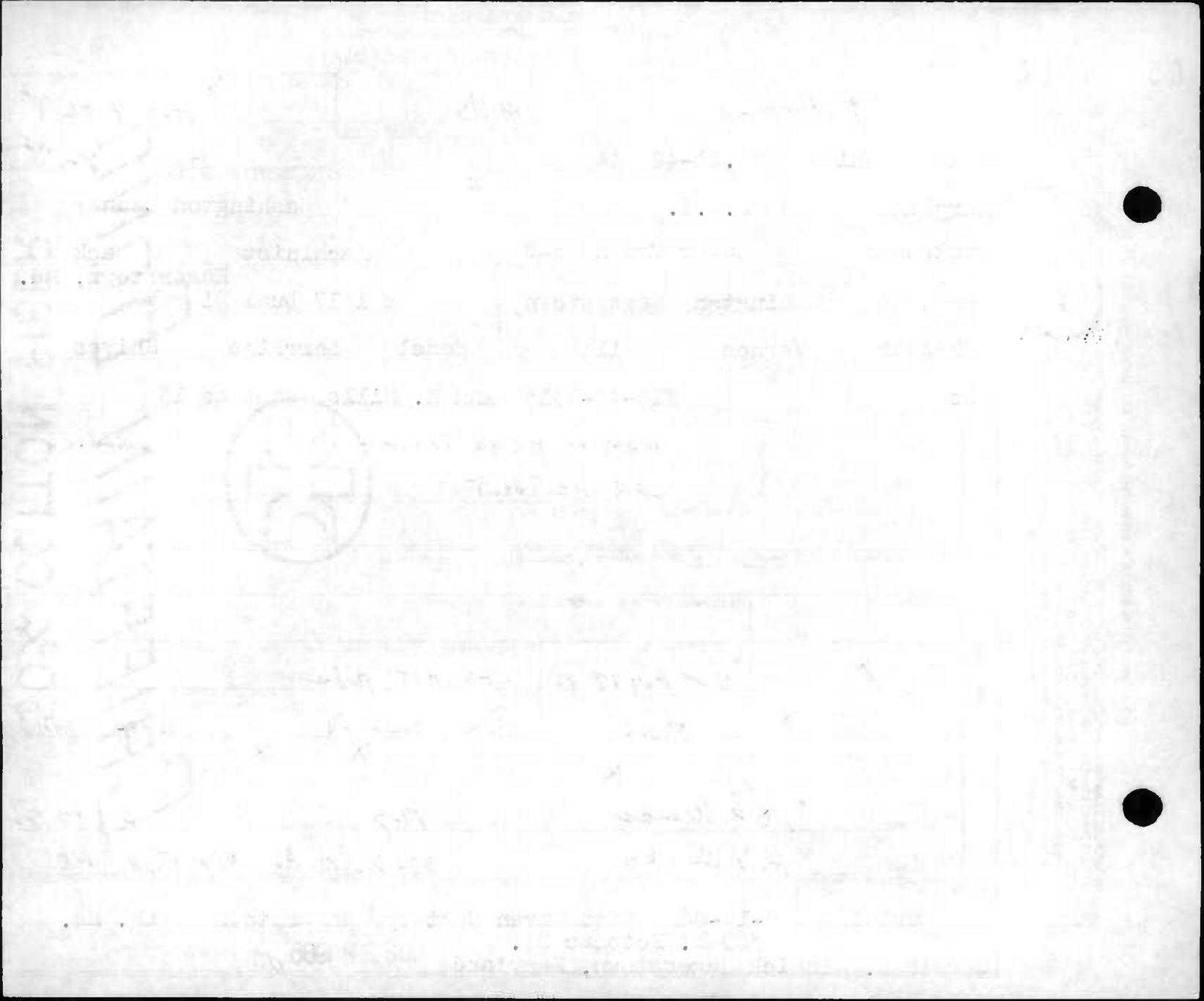
TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM "P-3" RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH. WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH												REG. NO. 24079			
1. FOR STATE REGISTRAR															
1. DECEASED NAME (TYPE OR PRINT) <b>F Horman</b>						FIRST <b>Mills</b>		MIDDLE		LAST		2a. DATE KNOWN OF DEATH ESTIMATED <b>Aug 17 1986</b>		2b. HOUR <b>7<sup>th</sup></b>	
3. SEX <b>Male</b>		4. RACE <b>White</b>		5. DATE OF BIRTH MONTH <b>Feb.</b> DAY <b>21</b> YEAR <b>42</b>		6. AGE (IN YEARS) (LAST BIRTHDAY) <b>44</b> YRS.		IF UNDER 1 YR. MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN		2c. DATE PRONOUNCED DEAD <b>Aug 17 1986</b>		2d. HOUR <b>7<sup>th</sup></b>	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Maryland</b>				7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>				8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>				9. BALTIMORE CITY OR COUNTY OF DEATH <b>Washington County</b> MD.			
10. CITY OR TOWN OF DEATH <b>Funkstown</b>				11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Beaver Creek Road</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Machinist</b>				12b. KIND OF BUSINESS OR INDUSTRY <b>Mack</b>			
USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)															
13a. STATE <b>Maryland</b>				13b. COUNTY <b>Washington</b>				13c. CITY OR TOWN <b>Hagerstown</b>				13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
13e. STREET ADDRESS <b>1617 Dual Hi Way</b>				13f. CITY OR TOWN <b>2140</b>											
14. FATHER'S NAME FIRST <b>Chester</b> MIDDLE <b>Vernon</b> LAST <b>Mills</b>				15. MOTHER'S MAIDEN NAME FIRST <b>Haael</b> MIDDLE <b>Lorraine</b> LAST <b>Shives</b>											
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) <b>No</b>				16b. SOCIAL SECURITY NO. <b>214-42-1313</b>				17. INFORMANT <b>Ann M. Mills</b>				ADDRESS <b>same as 13</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: <b>8159</b> IMMEDIATE CAUSE (a) <b>MASSIVE Head Trauma</b> Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost: <b>CAR ACCIDENT</b> (b) <b>CAR ACCIDENT</b> (c)												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>sudden</b>			
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a).															
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?								20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>7:20 AM Aug 17 1986</b>				21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2) <b>CAR HIT pole</b>							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK AT WORK				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) <b>Road</b>				21f. LOCATION STREET <b>Beaver Creek Rd</b>		CITY OR TOWN <b>WASH</b>		COUNTY <b>MD</b>			
22a. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> .															
ACTUAL SIGNATURE <b>H.N. Weeks</b>				TITLE (SPECIFY) <b>Dep</b>				M.D. <b>Aug 17, 86</b>				DATE SIGNED <b>Aug 17, 86</b>			
EXAMINER'S NAME (TYPE OR PRINT) <b>H.N. Weeks</b>				ADDRESS <b>580 Dunbar Ave Hagerstown MD</b>											
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>				23b. DATE <b>8-19-86</b>				23c. NAME OF CEMETERY OR CREMATORY <b>Rest Haven Cemetery</b>				23d. LOCATION CITY OR TOWN <b>Hagerstown</b> COUNTY <b>Wash.</b> STATE <b>Md.</b>			
24. FUNERAL DIRECTOR NAME <b>Gerald N. Minnich</b>				ADDRESS <b>305 N. Potomac St. Hagerstown, Maryland</b>				25a. DATE REC'D. BY REGISTRAR <b>AUG 22 1986</b>				25b. REGISTRAR'S SIGNATURE <b>Jana Davidson-Hopkins</b>			

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25M

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DHMH - 17  
(VR A15 ME (5))



00-16024

1. FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH24080  
REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST John Oliver MORRIS			2a. DATE OF DEATH MONTH DAY YEAR August 16, '86		2b. HOUR 10:30 P.M.	
3. SEX Male		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR 03 06 1906		
6. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? USA		8. AGE (IN YEARS LAST BIRTHDAY) 80 YRS		
9. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		10. CITY OR TOWN OF DEATH Hagerstown		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT INSUCH FACILITY, GIVE STREET ADDRESS) Washington County Hospital		
12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Manager		12b. KIND OF BUSINESS OR INDUSTRY Utility Co.		13. STREET ADDRESS / ZIP CODE 229 Willard Street 21740		
14. FATHER'S NAME FIRST MIDDLE LAST George Robert Morris		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Lottie May Shober		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) No		
16b. SOCIAL SECURITY NO. 179-09-6762A		17. INFORMANT ADDRESS Mr. Charles Martin Hagerstown, Md.		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>acute respiratory failure</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Chronic obstruction pulmonary disease</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u></u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost		
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a						
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)		
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE		
22a. I certify that (I) (the hospital) attended the deceased from <u>Feb</u> 19 <u>75</u> to <u>Aug 16</u> 19 <u>86</u> that (I) (we) lost saw the deceased alive on <u>Aug 16</u> 19 <u>86</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.						
22b. SIGNATURE <u>Harold R. Tritch Jr</u>		DEGREE <u>MD</u>		22c. DATE SIGNED <u>8-18-86</u>		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <u>HAROLD R. Tritch Jr</u>		22e. ADDRESS <u>HAGERSTOWN, Md. 21740</u>		22f. PHYSICIAN'S NAME (TYPE OR PRINT) <u>HAROLD R. Tritch Jr</u>		
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		23b. DATE <u>Aug. 20, 1986</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Jersey Shore</u>		
23d. LOCATION CITY OR TOWN COUNTY STATE <u>Jersey Shore Lycoming, Pa.</u>		24. FUNERAL DIRECTOR <u>MINNICH FUNERAL HOME</u>		25a. DATE REC'D. BY REGISTRAR <u>AUG 21 1986</u>		
25b. REGISTRAR'S SIGNATURE <u>Julia Davidson-Rendall</u>		25c. REGISTRAR'S SIGNATURE <u>Julia Davidson-Rendall</u>		25d. REGISTRAR'S SIGNATURE <u>Julia Davidson-Rendall</u>		

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

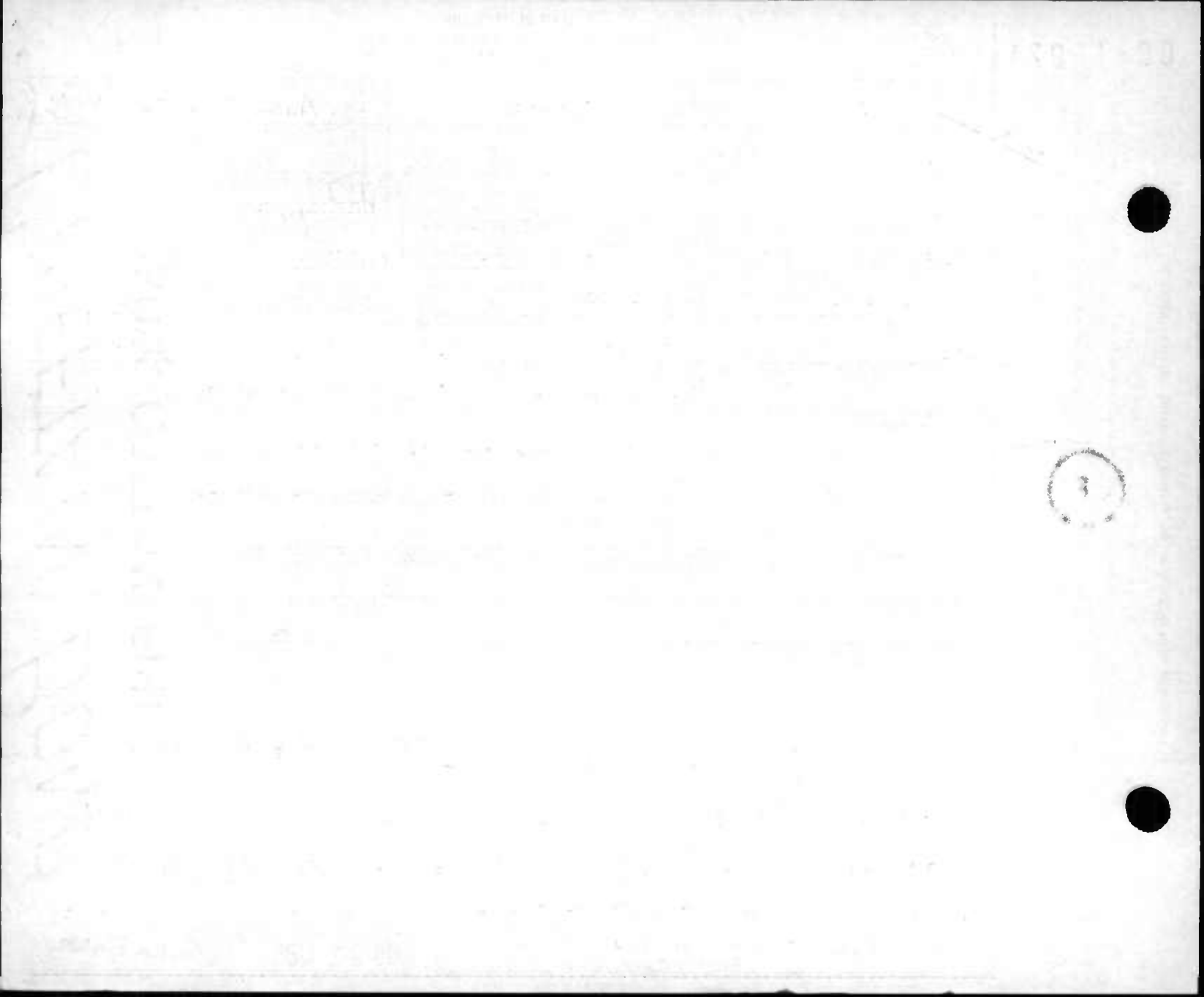
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please place above card in proper order. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked NO, it shows any injury, or other traumatic event, the medical examiner must be notified of cause.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

BP

DHMH - 16 60M 7/84  
(VRA 15, 4)



00-16834

DIVISION OF VITAL RECORDS, 301 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

BP

DHMM - 16 60M 7/73  
(VR A 15 (4))

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										24081 REG. NO.	
1. FOR STATE REGISTRAR		1. DECEASED NAME (TYPE OR PRINT) Kitty Louise Moxley				2a. DATE OF DEATH MONTH DAY YEAR 08-24-86				2b. HOUR 4:45PM	
3. SEX Female		4. RACE Negro		5. DATE OF BIRTH MONTH DAY YEAR 04-29-1900		6. AGE (IN YEARS LAST BIRTHDAY) 86 YRS.		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MARYLAND		7b. CITIZEN OF WHAT COUNTRY? UNITED STATES		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH WASHINGTON, MD.					
10. CITY OR TOWN OF DEATH Hagerstown		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Washington County Hospital				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Homemaker		12b. KIND OF BUSINESS OR INDUSTRY			
13a. STATE Md.		13b. COUNTY Wash.		13c. CITY OR TOWN Hancock		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 108 Fairview Drive 21750			
14. FATHER'S NAME FIRST MIDDLE LAST HENRY WILLIAMS				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST LOUISE REED							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 220 18 0901		17. INFORMANT R.L. Moxley, Jr.		ADDRESS 4356 Blagden Avenue, N.W. Washington, D.C. 20011					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiopulmonary arrest DUE TO, OR AS A CONSEQUENCE OF (b) Hypertension Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. DUE TO, OR AS A CONSEQUENCE OF (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH immediate 13 years											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)											
19a. DATE OF OPERATION none		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE							
22a. I certify that (I) (this hospital) attended the deceased from 5-18-19 59, to 8-24-19 86, that (I) (we) lost saw the deceased alive on 8-15-19 86, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
21b. SIGNATURE F.B. Thomas III M.D.				DEGREE M.D. ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>				22c. DATE SIGNED 08-25-86			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Frank B Thomas, III, M.D., P.A.				22e. ADDRESS Two Tonoloway Hancock, Maryland 21750							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL		23b. DATE 08/28/1986		23c. NAME OF CEMETERY OR CREMATORY RIVERVIEW		23d. LOCATION CITY OR TOWN COUNTY STATE HANCOCK, WASHINGTON, MARYLAND					
24. FUNERAL DIRECTOR NAME H. L. (unclear)				ADDRESS Hancock MD 21750				25a. DATE REC'D. BY REGISTRAR SEP 3 1986		25b. REGISTRAR'S SIGNATURE (unclear)	

MEDICAL CERTIFICATION

0-18834



00-15553

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

24082  
REG. NO.1- FOR  
STATE  
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) <b>James Edward MOWEN</b>			2a. DATE KNOWN OF DEATH EST. <input checked="" type="checkbox"/> MONTH DAY YEAR <b>Aug. 10 1986</b>			2b. HOUR OF DEATH <b>5:30 A M</b>	
3. SEX <b>male</b>	4. RACE <b>white</b>	5. DATE OF BIRTH MONTH DAY YEAR <b>Aug. 10, 1954</b>	6. AGE (IN YEARS) LAST BIRTHDAY <b>32 YRS.</b>	IF UNDER 1 YR. MONTHS DAYS HOURS MIN.	7c. DATE PRONOUNCED DEAD MONTH DAY YEAR <b>AUGUST 10 1986</b>	7d. HOUR <b>6:00 A M</b>	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Maryland</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Washington</b> MD.	
10. CITY OR TOWN OF DEATH <b>Hagerstown</b>		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Washington County Hospital</b>			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>aluminum</b>		12b. KIND OF BUSINESS OR INDUSTRY
13a. STATE <b>Maryland</b>		13b. COUNTY <b>Washington</b>		13c. CITY OR TOWN <b>Hagerstown</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
13e. STREET ADDRESS <b>1330 Delaware Lane</b>		13f. CITY OR TOWN <b>21740</b>					
14. FATHER'S NAME FIRST MIDDLE LAST <b>David E. Mowen</b>				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Georgiana C. Timbrook</b>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) (IF YES, GIVE WAR OR DATES) <b>yes 1978</b>		16b. SOCIAL SECURITY NO. <b>218-62-8412</b>		17. INFORMANT ADDRESS <b>Diane M. Mowen, Hagerstown, Md.</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>E-816 - MOTOR VEHICLE LOSING CONTROL AND RUNNING</b> DUE TO, OR AS A CONSEQUENCE OF <b>OFF ROAD AND OVERTURNING; VICTIM THROWN FROM VEHICLE</b> (b) <b>THROWN FROM VEHICLE</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>(MAJOR HEAD AND NECK TRAUMA)</b>							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>IMMED.</b>
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) <b>STATE Rt. #40</b>		21f. LOCATION STREET CITY OR TOWN COUNTY STATE <b>RT. 40 WEST, 2 MILES WEST CITY LIMITS, HAGERSTOWN, WASHINGTON, MD.</b>			
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE <i>Edward W. Ditto</i>		TITLE (SPECIFY) <b>DEPUTY</b>		MEDICAL EXAMINER		DATE SIGNED <b>Aug. 11, 1986</b>	
EXAMINER'S NAME (TYPE OR PRINT) <b>EDWARD W. DITTO, III, M.D.</b>		ADDRESS <b>217 WEST WASHINGTON STREET HAGERSTOWN, MARYLAND 21740</b>					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>burial</b>		23b. DATE <b>Aug. 13, 1986</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Rest Haven Cemetery</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Hagerstown, Wash., Maryland</b>	
24. FUNERAL DIRECTOR NAME ADDRESS <b>MINNICH FUNERAL HOME 415 E. Wilson Blvd., Hagerstown, Md. 21740</b>				25. DATE REC'D. BY REGISTRAR <b>AUG 14 1986</b>			
				25. REGISTRAR'S SIGNATURE <i>Julia Sanders-Rudace</i>			

DIVISION OF VITAL RECORDS, 301 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORMS 1, 2, AND 3. RETAIN PAGE 3 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP

DHMH - 17  
(VIR A15 ME (5))  
15M 7/76

0-12558

OFFICE OF THE  
JULIO  
AUGUST 10

PHOTO - 1 - 1000  
THROW FROM VEHICLE  
(LARGE HEAD AND NECK TRAUMA)

STATE ST. 1000  
WEST CITY, ILLINOIS  
RT. 10 WEST, 5 MILES

STATE ST. 1000  
WEST CITY, ILLINOIS  
RT. 10 WEST, 5 MILES

5  
00-17647

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked by item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH									
1. FOR STATE REGISTRAR		2. DATE OF DEATH		3. AGE		4. SEX		5. RACE	
1- REGISTRAR		8 27 86		77 YRS.		Female		White	
1. DECEASED NAME (TYPE OR PRINT)		2. DATE OF DEATH		3. AGE		4. SEX		5. RACE	
HAZEL N		8 27 86		77		Female		White	
6. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH		10. CITY OR TOWN OF DEATH	
Maryland		U.S.A.				Washington County		Hagerstown	
11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY		13a. STREET ADDRESS / ZIP CODE		13b. CITY OR TOWN	
Washington County Hospital		Seamstress		Wholesale Dress		331 Jefferson Street		Hagerstown	
14. FATHER'S NAME		15. MOTHER'S MAIDEN NAME		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT	
Clifford N. Bowman		Alice Hoover		No		217-12-1420		John E. Musey Jr.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY:		19. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?		21. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)	
IMMEDIATE CAUSE (a) Acute Anterior Wall Myocardial Infarction with extension				YES <input type="checkbox"/> NO <input type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>			
DUE TO, OR AS A CONSEQUENCE OF (b) Atherosclerotic Coronary Vessel Disease									
DUE TO, OR AS A CONSEQUENCE OF (c) 15 years									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?		21. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)	
				YES <input type="checkbox"/> NO <input type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)		21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	
		P.M. 19							
22a. I certify that (I) (this hospital) attended the deceased from Aug 12, 19 86 to Aug 27, 19 86, that (I) (we) last saw the deceased alive on Aug 26, 19 86, and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (If (we) (did) (did not) view the body after death.		22b. SIGNATURE		22c. DATE SIGNED		22d. PHYSICIAN'S NAME (TYPE OR PRINT)		22e. ADDRESS	
		Robert Brull		8/27/86		Robert Brull		1459 Potomac Ave. Hagerstown	
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (CITY OR TOWN, COUNTY, STATE)		24. FUNERAL DIRECTOR NAME	
Burial		8-29-86		Rose Hill Cemetery		Hagerstown Wash. Md.		305 N. Potomac St. Hagerstown, Maryland	
25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE		25c. REGISTRAR'S NAME		25d. REGISTRAR'S ADDRESS		25e. REGISTRAR'S PHONE NO.	
SEP 03 1986		Julia Dindorf-Randall		Julia Dindorf-Randall					

Washington County

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8

00-15001

1. FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 6

REG. NO.

2 4 0 8 4

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <b>LOLA M. NELSON</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>8-7-86</b>		2b. HOUR <b>6:25 PM</b>	
3. SEX <b>female</b>		4. RACE <b>Caucasian</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>12 18 1889</b>		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Maryland</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>96</b> YRS. MONTHS DAYS HOURS MIN.		
7c. CITY OR TOWN OF DEATH <b>Hagerstown</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Washington County Hospital</b>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Washington</b> MD.		
10. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE <b>Maryland</b>		13b. CITY OR TOWN <b>Braddock Heights</b>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Homemaker.</b>		
14. FATHER'S NAME FIRST MIDDLE LAST <b>George M. Nusbaum</b>		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Annie Winsing</b>		13c. STREET ADDRESS / ZIP CODE <b>Braddock Heights, 21714</b>		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>no</b>		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) <b>220-30-9851</b>		17. INFORMANT NAME ADDRESS <b>Nelson M. Pittinger, 1497 W. 9th St., Frederick, Md. 21701</b>		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cardiac arrest</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>acute myocardial infarction</b> DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a):						
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>		
21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1B, PART 1 OR PART 2)		21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		
21f. LOCATION STREET CITY OR TOWN COUNTY STATE		22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) lost saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.				
22b. SIGNATURE <b>A. W. H. P. H.</b>		DEGREE <b>MD</b>		22c. DATE SIGNED <b>8/7/86</b>		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>ABOUL WAHEED, MD</b>		22e. ADDRESS <b>1610 - OAK HILL AVE. HAGERSTOWN, MD</b>				
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>Aug 11, 1986</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Mt. Olivet Cemetery</b>		
23d. LOCATION CITY OR TOWN COUNTY STATE <b>Frederick Frederick Md.</b>		24. FUNERAL DIRECTOR NAME ADDRESS <b>Smith Kennedy Eslerford P.A. Funeral Home 106 E. Church St., Fred. Md. 21701</b>				
25a. DATE REC'D. BY REGISTRAR <b>AUG 12 1986</b>		25b. REGISTRAR'S SIGNATURE <b>Julia Tondora-Randall</b>				

MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked, item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP



0-16405

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

86 24085

FOR  
1. STATE  
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <b>Mary Georgia Norford</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>August 15, 1986</b>		2b. HOUR MIN. SEC. <b>12:25 A M</b>		
3. SEX <b>Female</b>		4. RACE <b>White</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>Jan. 18, 1906</b>		6. AGE (IN YEARS LAST BIRTHDAY) YRS MONTHS DAYS <b>80</b>	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Maryland</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Washington County MD.</b>	
10. CITY OR TOWN OF DEATH <b>Hagerstown</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Washington County Hospital</b>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Manager</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>Retail Stand</b>	
13a. STATE <b>Maryland</b>		13b. COUNTY <b>Washington</b>		13c. CITY OR TOWN <b>Hagerstown</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>Unknown</b>		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Ruth Norford</b>		16. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>No</b>		17. INFORMANT <b>George Hoffman 430 Pangborn Blvd.</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>ARTERIOSCLEROTIC HEART DISEASE WITH ATRIAL</b> DUE TO, OR AS A CONSEQUENCE OF <b>AND</b> <b>FIBRILLATION</b> (b) <b>EXTENSIVE CELLULITIS OF RT. BUTTOCK</b> DUE TO, OR AS A CONSEQUENCE OF <b>AND</b> <b>DIABETES MELLITUS, TYPE I</b> (c) <b>MANY YEARS</b> <b>4 - 5 WEEKS</b> <b>MANY YEARS</b>		19. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1b. PART I OR PART 2)	
21d. INJURY OCCURRED		21e. PLACE OF INJURY (AT HOME STREET FACTORY OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE		22a. DATE SIGNED <b>Aug. 15, 1986</b>	
22b. SIGNATURE <i>Edward W. Ditto</i>		22c. PHYSICIAN'S NAME (TYPE OR PRINT) <b>EDWARD W. DITTO, III, M.D.</b>		22d. ADDRESS <b>217 WEST WASHINGTON STREET HAGERSTOWN, MARYLAND 21740</b>		22e. DATE RECD. BY REGISTRAR <b>AUG 22 1986</b>	
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>8-18-86</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Rose Hill Cemetery Hagerstown Wash. Md.</b>		23d. LOCATION CITY OR TOWN COUNTY STATE	
24. FUNERAL DIRECTOR NAME <b>Gerald N. Minnich Hagerstown, Maryland</b>		25a. DATE RECD. BY REGISTRAR <b>AUG 22 1986</b>		25b. REGISTRAR'S SIGNATURE <i>John Davidson</i>		25c. REGISTRAR'S NAME <b>John Davidson</b>	

MEDICAL CERTIFICATION

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.

(b) **EXTENSIVE CELLULITIS OF RT. BUTTOCK**  
(c) **DIABETES MELLITUS, TYPE I**

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:

19a. DATE OF OPERATION

19b. CONDITION FOR WHICH OPERATION WAS PERFORMED

20a. AUTOPSY?

20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?

21a. ACCIDENT WAS UNDERLYING ☐  
OR CONTRIBUTING ☐ CAUSE OF DEATH  
(IF EITHER, NOTIFY MEDICAL EXAMINER)

21b. TIME OF INJURY  
HOUR A.M. MONTH DAY YEAR  
P.M. 19

21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1b. PART I OR PART 2)

21d. INJURY OCCURRED

21e. PLACE OF INJURY  
(AT HOME STREET FACTORY OFFICE, FARM, ETC.)

21f. LOCATION

CITY OR TOWN

COUNTY

STATE

22a. I certify that (1) ~~XXXXXX~~ attended the deceased from **JULY 26**, 19 **86**, to **AUGUST 14**, 19 **86**, that (1) ~~XX~~ lost saw the deceased alive on above, (1) ~~XXXXXX~~ (did not) view the body after death. and that in my ~~XX~~ opinion death occurred on the date and hour and from the causes stated

22b. SIGNATURE

DEGREE

ATTENDING PHYSICIAN ☒ MEDICAL DIRECTOR ☐ STAFF PHYSICIAN ☐

22c. DATE SIGNED

22d. PHYSICIAN'S NAME (TYPE OR PRINT)

22e. ADDRESS

**217 WEST WASHINGTON STREET  
HAGERSTOWN, MARYLAND 21740**

23a. BURIAL, CREMATION, REMOVAL (SPECIFY)

23b. DATE

23c. NAME OF CEMETERY OR CREMATORY

23d. LOCATION

CITY OR TOWN

COUNTY

STATE

24. FUNERAL DIRECTOR NAME

305 N. Potomac St.

25a. DATE RECD. BY REGISTRAR

25b. REGISTRAR'S SIGNATURE

**Gerald N. Minnich Hagerstown, Maryland**

**AUG 22 1986**

*John Davidson*



ATTENTION DEPT. OF JUSTICE  
EXTENSIVE RESEARCH  
DIAGNOSTIC RESEARCH, TYPE 1

THIRTY-THREE  
DAVID M. HARRIS, PHOTODUPLICATION

THIRTY-THREE



0-81743

1- FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 6 2 4 0 8 6

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) <b>Louise Mildred PALMER</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>August 26, 1986</b>		2b. HOUR <b>5:30PM</b>		
3. SEX <b>Female</b>		4. RACE <b>White</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>May 19, 1919</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>67</b> YRS	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Benevola, Md.</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Washington</b> MD	
10. CITY OR TOWN OF DEATH <b>Boonsboro</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>1 Young Ave.</b>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Housewife</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>Own Home</b>	
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE <b>Maryland</b>		13b. COUNTY <b>Washington</b>		13c. CITY OR TOWN <b>Boonsboro</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>Fred Lee Baker</b>		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Clemmie Elnora Smith</b>		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>No</b>		16b. SOCIAL SECURITY NO. <b>218-10-0135</b>	
17. INFORMANT ADDRESS <b>1 Young Ave. Boonsboro, Md. 21713</b>		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>pneumonia - unknown cause</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>chronic obstructive lung disease</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>cigarette smoking</b>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <b>no</b>							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) last saw the deceased alive on _____, 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE <b>Andrew L. Gunn</b>				DEGREE <b>MD</b>		22c. DATE SIGNED <b>8/28/86</b>	
23a. PHYSICIAN'S NAME (TYPE OR PRINT) <b>Andrew L. Gunn</b>				23b. ADDRESS <b>100 Geeting Lane, Keedysville, Md. 21756</b>			
23a. BURIAL, CREMATION, REMOVAL (CHECK BY) <b>Burial</b>		23b. DATE <b>8-30-86</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Boonsboro Cemetery</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Boonsboro, Wash. Co., Md.</b>	
24. FUNERAL DIRECTOR NAME ADDRESS <b>John H. Bast, Jr. Boonsboro, Md. 21713</b>				25a. DATE REC'D. BY REGISTRAR <b>SEP 2 1986</b>		25b. REGISTRAR'S SIGNATURE <b>Julia Davidson-Randall</b>	

MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the health department. Page 4 may be retained by the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

BP



1- FOR  
STATE  
REGISTRAR **CLARICE MAE PLACE**

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 6 2 4 0 8 7

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <b>Clarice Mae Place</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>8 24 86</b>		2b. HOUR <b>1<sup>24</sup> A.M.</b>		
3. SEX <b>Female</b>		4. RACE <b>White</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>Jan. 25, 1908</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>78</b> YRS.	
7. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>West Virginia</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Washington County</b> MD.	
10. CITY OR TOWN OF DEATH <b>Hagerstown</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Washington County Hospital</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>School Teacher</b>	

13a. STATE <b>Maryland</b>			13b. COUNTY <b>Washington</b>		13c. CITY OR TOWN <b>Hagerstown</b>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE <b>Route # 9 Box 201</b> <b>21740</b>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>Joseph Ray Ambrose</b>			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Mary Elizabeth Bryd</b>			16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>No</b>				
16b. SOCIAL SECURITY NO. <b>233-34-3046</b>			17. INFORMANT <b>Joseph R. Place Hagerstown, Md.</b>							

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).  
PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) **CARDIAC ARREST**

DUE TO, OR AS A CONSEQUENCE OF

Conditions, if any, which  
gave rise to immediate  
cause (a), stating the  
underlying cause last.

(b) **CACINOMATOSIS**

DUE TO, OR AS A CONSEQUENCE OF

(c)

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)

19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>8/24 19 86</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1b. PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from <b>8/24 19 86</b> to <b>8/24 19 86</b> , that (I) (we) last saw the deceased alive on <b>8/24 19 86</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE <b>GERALD D. SCALLIN</b>				DEGREE <b>Attending Physician</b>		22c. DATE SIGNED <b>8/25/86</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT)				22e. ADDRESS			
<b>GERALD D. SCALLIN</b>				<b>645 E. First St. Hagerstown, Md.</b>			

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>8-27-86</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Rest Haven Cemetery Hagerstown, Washington, Md.</b>		23d. LOCATION CITY OR TOWN COUNTY STATE	
24. FUNERAL DIRECTOR NAME <b>A.K. Coffman Funeral Home, Inc.</b>				25a. DATE REC'D. BY REGISTRAR <b>AUG 27 1986</b>		25b. REGISTRAR'S SIGNATURE <b>[Signature]</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

20% COTTON FIBER

CLARK COUNTY

Jan. 22, 1902

Washington County, U.S.A.

Washington County, U.S.A.

Washington County, U.S.A.

Washington County, U.S.A.

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Washington County, U.S.A.

00-16407

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM 10M. 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP

DHMH - 17  
(VR A15 ME (1))  
20M 4/82

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

24088  
REG. NO.

1- STATE REGISTRAR										2a. DATE KNOWN OF DEATH										2b. HOUR																																																																																									
1. DECEASED NAME (TYPE OR PRINT)										2a. DATE KNOWN OF DEATH										2b. HOUR																																																																																									
Mervil Leon Price Sr										8 17 1986										9 45 AM																																																																																									
3. SEX			4. RACE			5. DATE OF BIRTH			6. AGE (IN YEARS)			IF UNDER 1 YR.			IF UNDER 24 HRS.			2c. DATE PRONOUNCED DEAD			2d. HOUR																																																																																								
Male			White			July 30-1913			73 YRS.			MONTHS			DAYS			8 17 1986			12 PM																																																																																								
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)					7b. CITIZEN OF WHAT COUNTRY?					8. MARRIED					9. BALTIMORE CITY OR COUNTY OF DEATH					10. CITY OR TOWN OF DEATH					11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION					12a. USUAL OCCUPATION (TYPE OF WORK)					12b. KIND OF BUSINESS OR INDUSTRY																																																																										
West Virginia					U.S.A.					WIDOWED					Washington					Hagerstown					1038 Security Road					Assembly					Fairchild																																																																										
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Maryland										Washington										Hagerstown										YES										NO										1038 Security Road										21740																																																	
14. FATHER'S NAME										15. MOTHER'S MAIDEN NAME										16a. WAS DECEASED EVER IN U.S. ARMED FORCES?										16b. SOCIAL SECURITY NO.										17. INFORMANT										18. CAUSE OF DEATH										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH																																																	
Martin Luther Price										Florence O'Flynn										No										020-01-5716										Mervil L. Price, Jr. PO. 3611										Suicide (Firearms) E955																																																											
19a. DATE OF OPERATION										19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?										20. AUTOPSY?										21a. EXTERNAL CAUSE WAS										21b. TIME OF INJURY										21c. HOW INJURY OCCURRED										21d. INJURY OCCURRED										21e. PLACE OF INJURY										21f. LOCATION										21g. LOCATION																			
										Severe pneumonia, heart disease										YES										NO										UNDERLYING										9 45 AM										8 17 1986										Gunshot wound into mouth										None										1038 Security Rd Hagerstown Wash MD										21g. LOCATION									
21a. EXTERNAL CAUSE WAS										21b. TIME OF INJURY										21c. HOW INJURY OCCURRED										21d. INJURY OCCURRED										21e. PLACE OF INJURY										21f. LOCATION										21g. LOCATION																																																	
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STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

24089  
REG. NO.

1- FOR  
STATE  
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) <b>EMIL GEORGE REYSZ</b>			2a. DATE KNOWN OF DEATH ESTIMATED <input checked="" type="checkbox"/> MONTH DAY YEAR <b>8-6 1986</b>			2b. HOUR <b>6:30 A</b>		
3. SEX <b>Male</b>	4. RACE <b>White</b>	5. DATE OF BIRTH MONTH DAY YEAR <b>April 7, 1907</b>	6. AGE IN YEARS (LAST BIRTHDAY) <b>79</b> YRS.	IF UNDER 1 YR. MONTHS DAYS HOURS MIN.	IF UNDER 24 HRS. MONTHS DAYS HOURS MIN.	2c. DATE PRONOUNCED DEAD MONTH DAY YEAR <b>8-6 1986</b>	2d. HOUR <b>9:15 A</b>	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Ridgefield, N. J.</b>			7b. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>			8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		
10. CITY OR TOWN OF DEATH <b>Boonsboro</b>			11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Rd. 2 Box 392</b>			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Street Maintenance Worker</b>		

13a. STATE <b>Maryland</b>			13b. COUNTY <b>Washington</b>			13c. CITY OR TOWN <b>Boonsboro</b>		
14. FATHER'S NAME FIRST MIDDLE LAST <b>John Michael Reysz</b>			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Mary Neckla</b>			13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) <b>No</b>			16b. SOCIAL SECURITY NO. <b>146-09-6189</b>			17. INFORMANT ADDRESS <b>Rd. 2 Box 392</b> <b>Mrs. Lena A. Reysz, Boonsboro, Md. 21713</b>		

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>CARDIAC TAMPONADE - 423</b> DUE TO, OR AS A CONSEQUENCE OF <b>ACUTE MYOCARDIAL INFARCT - 410 HOURS</b> (b) <b>ARTERIOSCLEROTIC CARDIAC VASCULAR DISEASE - 429</b> (c)		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
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PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I		
19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?	20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH P.M. 19	21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)	21f. LOCATION STREET CITY OR TOWN COUNTY STATE

22a. I certify that I took charge of the remains described above, held on death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion		
ACTUAL SIGNATURE <b>George Milic</b>	TITLE (SPECIFY) <b>DEPUTY</b>	DATE SIGNED <b>8-6-86</b>
EXAMINER'S NAME (TYPE OR PRINT) <b>GEORGE MILIC, M.D.</b>	ADDRESS <b>40 MANOR DR #103 HAGERSTOWN - MD-21740</b>	

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>	23b. DATE <b>8-8-86</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Rest Haven Cemetery</b>	23d. LOCATION CITY OR TOWN COUNTY STATE <b>Hagerstown, Wash. Co., Md.</b>
24. FUNERAL DIRECTOR NAME ADDRESS <b>John H. Bast, Jr. Boonsboro, Md. 21713</b>		25a. DATE REC'D. BY REGISTRAR <b>AUG 8 1986</b>	25b. REGISTRAR'S SIGNATURE <b>Julia Davidson</b>

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGE NO. 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORMS 1, 2, 3, 4, 5, 6, 7, 8, 9, 10, 11, 12, 13, 14, 15, 16, 17, 18, 19, 20, 21, 22, 23, 24, 25, 26, 27, 28, 29, 30, 31, 32, 33, 34, 35, 36, 37, 38, 39, 40, 41, 42, 43, 44, 45, 46, 47, 48, 49, 50, 51, 52, 53, 54, 55, 56, 57, 58, 59, 60, 61, 62, 63, 64, 65, 66, 67, 68, 69, 70, 71, 72, 73, 74, 75, 76, 77, 78, 79, 80, 81, 82, 83, 84, 85, 86, 87, 88, 89, 90, 91, 92, 93, 94, 95, 96, 97, 98, 99, 100. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH. WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD, 21201

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April 1, 1907

W. B. ...

Box 192

Washington

Michael

No



2-NSN

DEPT

N.D.

East Haven Cemetery

John H. Beac, Jr. Boxboro, Ma. 01521



00-16216

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please return this certificate to the State Dept. of Health and Mental Hygiene prior to burial, cremation, or other final disposition.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

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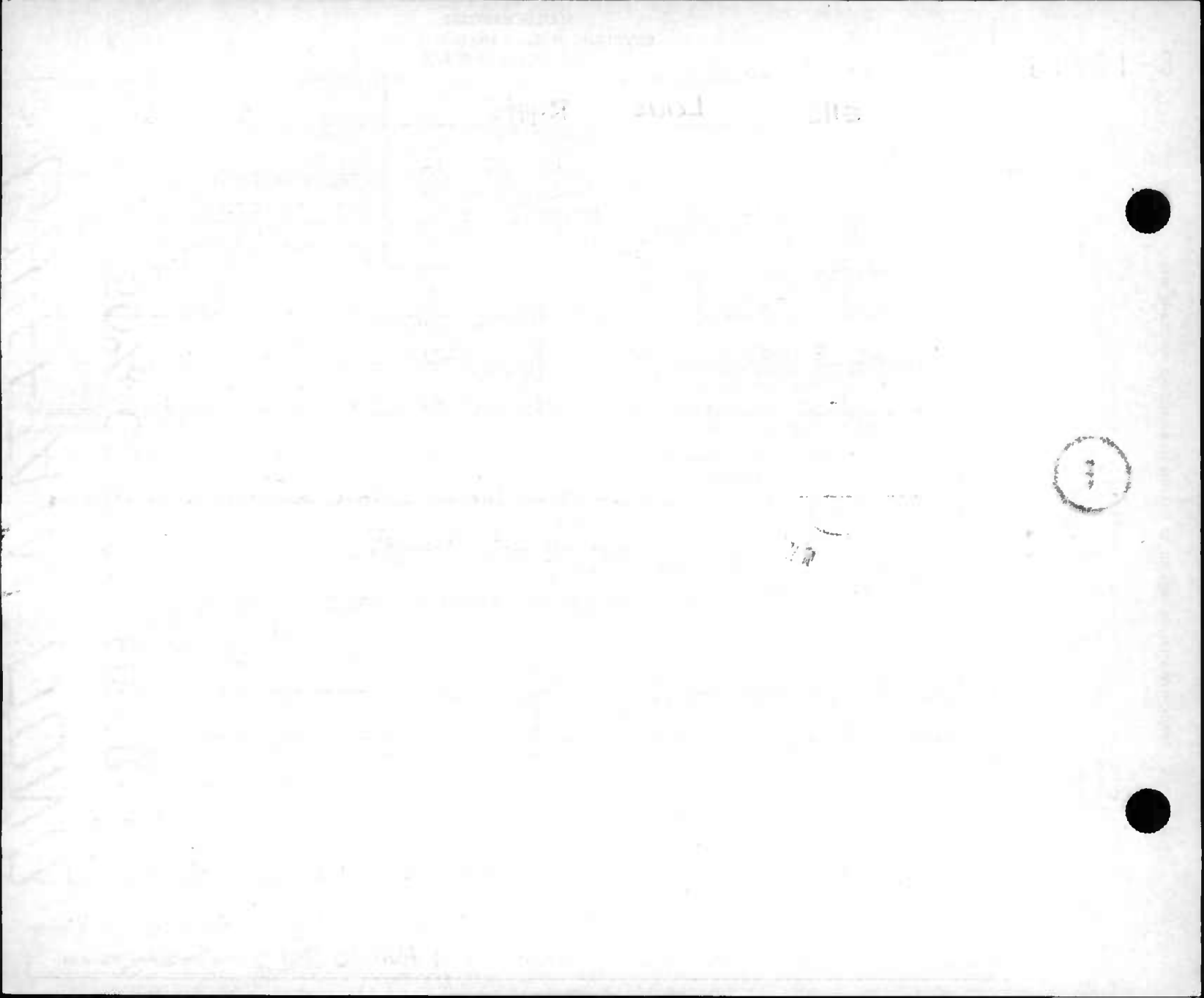
REG. NO.

1. FOR  
STATE  
REGISTRAR

ELLA LOUIS RIPPLE

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <b>ELLA LOUIS Ripple</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>8 20 86</b>		2b. HOUR M <b>M</b>	
3. SEX <b>Female</b>		4. RACE <b>White</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>1 15 14</b>		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Maryland</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		6. AGE (IN YEARS LAST BIRTHDAY) YRS. MONTHS DAYS <b>72</b>		
10. CITY OR TOWN OF DEATH <b>Hagerstown</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>109 Elm Street</b>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Washington County</b> MD.		
13a. STATE <b>Maryland</b>		13b. COUNTY <b>Washington</b>		13c. CITY OR TOWN <b>Hagerstown</b>		
14. FATHER'S NAME FIRST MIDDLE LAST <b>Thomas Blundell Allen</b>		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Annie Myrtle Durrett</b>		12a. USUAL OCCUPATION (TYPE OF WORK OR MOST OF WORKING LIFE) <b>Self Employed</b>		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>No</b>		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) <b>220-16-3385</b>		17. INFORMANT ADDRESS <b>328 South Locust St. Hagerstown, Maryland</b>		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) _____ DUE TO, OR AS A CONSEQUENCE OF (b) <b>ca of Lt. Kidney &amp; Wide metastasis</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause - last. } DUE TO, OR AS A CONSEQUENCE OF (c) <b>ca of Lt. Breast</b> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>few mos</b> <b>Months</b>						
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <b>D.M. ASHD</b>						
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1B, PART 1 OR PART 2)		
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE		
22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) lost saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.						
22b. SIGNATURE <b>[Signature]</b>				22c. DATE SIGNED <b>8-21-86</b>		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>W. B. KANG</b>				22e. ADDRESS <b>1933 Va. Ave. Hagerstown, Md</b>		
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>8-23-86</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Rose Hill Cemetery</b>		
24. FUNERAL DIRECTOR NAME <b>A.K. Coffman Funeral Home, Inc.,</b>		ADDRESS <b>Hagerstown, Md.</b>		25a. DATE REC'D. BY REGISTRAR <b>AUG 25 1986</b>		
				25b. REGISTRAR'S SIGNATURE <b>[Signature]</b>		

BP \_\_\_\_\_



00-14936

1. FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

6 24091

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) <b>MELVYN STUART ROSENTHAL</b> <i>Melvyn S. Rosenthal</i>				2a. DATE OF DEATH MONTH DAY YEAR <b>8 5 86</b>				2b. HOUR <b>10 30 A</b>	
3. SEX <b>Male</b>		4. RACE <b>White</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>May 1, 1938</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>48</b> YRS.		7. IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>New York</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Washington County</b> MD.			
10. CITY OR TOWN OF DEATH <b>Hagerstown</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>1612 The Terrace</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Owner</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>Furniture Store</b>	
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE <b>Maryland</b>				13b. COUNTY <b>Washington</b>		13c. CITY OR TOWN <b>Hagerstown</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
13e. STREET ADDRESS / ZIP CODE <b>1612 The Terrace 21740</b>				14. FATHER'S NAME FIRST MIDDLE LAST <b>Joseph Rosenthal</b>		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Beatrice Wechsler</b>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>No</b>		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) <b>051-30-2349</b>		17. INFORMANT ADDRESS <b>1612 The Terrace Hagerstown, Md.</b>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Carcinoma of colon</b> DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>22 months</b>	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1B PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from <b>7/24/86</b> to <b>8/15/86</b> , that (I) (we) lost saw the deceased alive or above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE <i>Frederic H. Kass III</i>				DEGREE <i>MD</i> ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>				22c. DATE SIGNED <b>8/6/86</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>Frederic H. Kass III</b>				22e. ADDRESS <b>1925 Howell Rd Hagerstown Md</b>					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>8-7-86</b>		23c. NAME OF CEMETERY OR CREMATORY <b>B'Nai Abraham Cemetery Halfway, Washington,</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Md.</b>			
24. FUNERAL DIRECTOR NAME <b>AK Co Hines Funeral Home, Inc</b>				25a. DATE REC'D. BY REGISTRAR <b>AUG 11 1986</b>		25b. REGISTRAR'S SIGNATURE <i>Julia Davidson-Gardner</i>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be examined within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 4 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP

UNITED STATES DEPARTMENT OF JUSTICE

May 1, 1958

Washington, D.C.

Mr. J. Edgar Hoover

Director, Federal Bureau of Investigation

Special Agent

Mr. Rosen

Re: [illegible]

[illegible]

Very truly yours,  
[illegible]

cc: [illegible]

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of such.

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 6

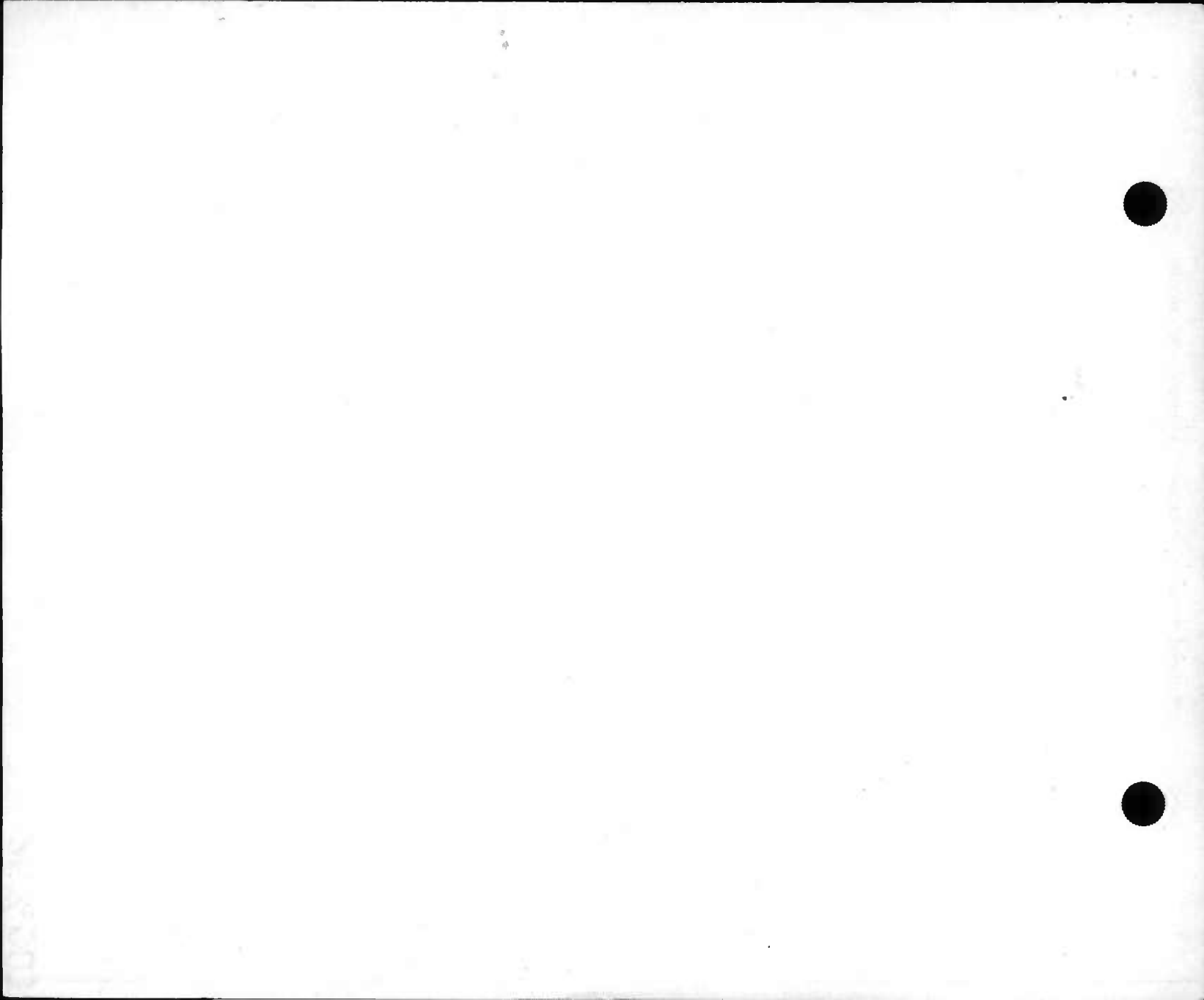
REG. NO.

2 4 0 9 2

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Frances M. ay SCHEETZ			2a. DATE OF DEATH MONTH DAY YEAR August 7 1986		2b. HOUR 11.30 PM
3. SEX FEMALE	4. RACE WHITE	5. DATE OF BIRTH MONTH DAY YEAR 05 15 1918	6. AGE (IN YEARS LAST BIRTHDAY) 68 YRS		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) ENGLAND	7b. CITIZEN OF WHAT COUNTRY? USA	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH Washington MD.		
10. CITY OR TOWN OF DEATH Williamsport	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Williamsport Nursing Home		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) HOUSEWIFE	12b. KIND OF BUSINESS OR INDUSTRY	
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE MD			13b. CITY OR TOWN FREDERICK	13c. CITY OR TOWN FREDERICK	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
14. FATHER'S NAME FIRST MIDDLE LAST WILLIAM HENRY SMITH			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST SARA ANN		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, GIVE WAR OR DATES) NO		16b. SOCIAL SECURITY NO. N/A	17. INFORMANT ADDRESS Carol Ann Everett Williamsport, MD P. O. Box 509		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Metastatic cervical cancer</u> DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) _____					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> (OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from <u>8/6</u> , 19 <u>86</u> , to <u>8/7</u> , 19 <u>86</u> , that (I) <u>we</u> lost saw the deceased alive on <u>8/7</u> , 19 <u>86</u> , and that in <u>my</u> (our) opinion death occurred on the date and hour and from the causes stated above, (I) <u>we</u> (did) (did not) view the body after death.					
22b. SIGNATURE <u>John R. Melnick</u>		DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input checked="" type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) John R. Melnick		22e. ADDRESS 16220 Frederick Road Gaithersburg, MD 20877			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL	23b. DATE 8/11/86	23c. NAME OF CEMETERY OR CREMATORY Resthaven Mem. Gardens		23d. LOCATION CITY OR TOWN COUNTY STATE Frederick Frederick MD	
24. FUNERAL DIRECTOR NAME G. Douglas Stauffer		25a. DATE REC'D. BY REGISTRAR AUG 12 1986		25b. REGISTRAR'S SIGNATURE <u>Davidson-Randall</u>	
1621 Opossumtown Pike, Frederick, MD 21701					

BP

DHMH-16 20M  
(VRA 15, 4) 7/78



00-15735

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

86 24093

REG. NO.

1- FOR  
STATE  
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) Ann MACKAY SCHOEN			2a. DATE OF DEATH MONTH DAY YEAR July 31, 1986		2b. HOUR 6:00P M
3. SEX Female	4. RACE Caucasian	5. DATE OF BIRTH MONTH DAY YEAR November 13, 1897		6. AGE (IN YEARS LAST BIRTHDAY) 88 YRS.	IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) New York	7b. CITIZEN OF WHAT COUNTRY? USA	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Washington, MD.	
10. CITY OR TOWN OF DEATH Williamsport	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Homewood Retirement Center		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Statistician/Ret.	12b. KIND OF BUSINESS OR INDUSTRY None	
13a. STATE Maryland		13b. COUNTY Washington	13c. CITY OR TOWN Williamsport	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET ADDRESS / ZIP CODE 2750 Virginia Avenue 21795
14. FATHER'S NAME FIRST MIDDLE LAST William Mackay		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Pauline Veit			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. 052-05-3417		17. INFORMANT ADDRESS Mrs. Walter E. Frey 1028 N. Market St. Frederick, Md. 21701	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1: DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>RESPIRATORY FAILURE</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: (b) <u>MASSIVE INTRACRANIAL BLEED</u> DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH					
PART 2: OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (b)					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1, OR PART 2)	
21d. INJURY OCCURRED TITLE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE 86 7/31 86	
22a. I certify that (a) (this hospital) attended the deceased from 8/2/86 to 7/31 19 86 that (b) (we) last saw the deceased alive on 8/2/86, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above.					
22b. SIGNATURE <i>[Signature]</i>		DEGREE M.D. ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		22c. DATE SIGNED 8/1/86	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Stephen E. Metzner M.D.		22e. ADDRESS 1825 Howell Rd Hagerstown, Md 21740			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 8/3/86	23c. NAME OF CEMETERY OR CREMATORY St. Johns Cath. Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Queens, Queens, New York
24. FUNERAL DIRECTOR <i>[Signature]</i>		1201 N. Market St. R. E. Dailey & Son P.A.		25a. DATE REC'D. BY REGISTRAR AUG 18 1986	
		Frederick, Md. 21701		25b. REGISTRAR'S SIGNATURE <i>[Signature]</i>	

MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use on the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

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MILTON

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Robert Milton Miny  
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May 2

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0-16311

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 24 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 22 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1- FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

8 6 2 4 0 9 4

1. DECEASED NAME (TYPE OR PRINT) FIRST <u>Barbara</u> MIDDLE <u>Lorraine</u> LAST <u>Semler</u> <i>Barbara L. Semler</i>			2a. DATE OF DEATH MONTH <u>08</u> DAY <u>21</u> YEAR <u>86</u>		2b. HOUR <u>4<sup>25</sup></u> P.M.	
3. SEX <u>Female</u>	4. RACE <u>White</u>	5. DATE OF BIRTH MONTH <u>March</u> DAY <u>3</u> YEAR <u>1953</u>		6. AGE (IN YEARS LAST BIRTHDAY) <u>33</u> YRS.		IF UNDER 1 YEAR MONTHS <u></u> DAYS <u></u>
7a. BIRTHPLACE (COUNTRY) <u>Maryland</u>	7b. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <u>Washington</u> MD.		
10. CITY OR TOWN OF DEATH <u>Hagerstown</u>	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <u>Washington County Hospital</u>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY	
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE <u>Md.</u> 13b. COUNTY <u>Wash.</u> 13c. CITY OR TOWN <u>Smithsburg</u>			13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET ADDRESS / ZIP CODE <u>Rt. 1, Box 3</u> <u>21783</u>		
14. FATHER'S NAME FIRST <u>Richard</u> MIDDLE <u>L.</u> LAST <u>Semler</u>			15. MOTHER'S MAIDEN NAME FIRST <u>Helen</u> MIDDLE <u>L.</u> LAST <u>Bachtell</u>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <u>no</u>		16b. SOCIAL SECURITY NO. <u>220-74-6783</u>		17. INFORMANT ADDRESS <u>Mrs. Helen L. Bachtell, Smithsburg, Md.</u>		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pulmonary Embolism</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH						
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: _____						
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <u>P.M.</u> <u>19</u>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)		
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE		
22a. I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) last saw the deceased alive on _____, 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.						
22b. SIGNATURE <u>ABDUL WATTERED</u>		DEGREE <u>MD</u>		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED <u>8/21/86</u>
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <u>ABDUL WATTERED</u>		22e. ADDRESS <u>1610 - OAK HILL AVE. HAG. MD 21740</u>				
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>	23b. DATE <u>Aug. 25, 1986</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Rest Haven Cemetery</u>		23d. LOCATION CITY OR TOWN <u>Hagerstown</u> COUNTY <u>Wash.</u> STATE <u>Md.</u>		
24. FUNERAL DIRECTOR NAME <u>Dennis L. Davis</u>		ADDRESS <u>Davis Funeral Home, Smithsburg, Md., 21783</u>		25a. DATE REC'D. BY REGISTRAR <u>AUG 26 1986</u>		
				25b. REGISTRAR'S SIGNATURE <u>L. L. Linder</u>		

BP

1001



3  
00-81789

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

6 24095  
REG. NO.

1. FOR  
STATE  
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) FIRST Paul MIDDLE B. LAST Shade <b>PAUL B. SHADE</b>			2a. DATE OF DEATH MONTH DAY YEAR August 17, 1986		2b. HOUR 6:30p.m.	
3. SEX Male		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR Dec. 31, 1910		
6. AGE (IN YEARS LAST BIRTHDAY) 75 YRS.		7. BIRTHPLACE (STATE OR FOREIGN COUNTRY) West Virginia		8. CITIZEN OF WHAT COUNTRY? USA		
9. BALTIMORE CITY OR COUNTY OF DEATH Washington County, MD.		10. CITY OR TOWN OF DEATH Hagerstown		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Washington County Hospital		
12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Farmer		12b. KIND OF BUSINESS OR INDUSTRY Agriculture		13. STREET ADDRESS / ZIP CODE P. O. Box 32 21782		
13a. STATE Maryland		13b. COUNTY Washington		13c. CITY OR TOWN Sharpsburg		
14. FATHER'S NAME FIRST MIDDLE LAST Braden O. Shade		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Nannie L. Catlett		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) No		
16b. SOCIAL SECURITY NO. 235-12-1798		17. INFORMANT Twila M. Shade, Sharpsburg, MD 21782		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>RESPIRATORY ARREST</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>ACUTE RESPIRATORY FAILURE</u> (c) <u>EMPHYSEMA/CHRONIC BRONCHITIS</u>		

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a) \_\_\_\_\_

19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) last saw the deceased alive on _____, 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE <i>CD WOOSTER MD</i>				DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 8/18/86	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) CD WOOSTER MD				22e. ADDRESS 1825 HOWELL ROAD HOOST MD			

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 8/20/86		23c. NAME OF CEMETERY OR CREMATORY Pleasant View Mem.Gds.		23d. LOCATION CITY OR TOWN COUNTY STATE Martinsburg Berkeley WV	
24. FUNERAL DIRECTOR Charles M. Brown 327 W. King St Brown Funeral Home POBox 821, Martinsburg, WV				25a. DATE REC'D. BY REGISTRAR AUG 22 1986		25b. REGISTRAR'S SIGNATURE <i>Julia Fisher</i>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 48 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.



3  
0-81787

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

6 2 4 0 9 6

1- STATE REGISTRAR

REG. NO.

1 DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <b>FRANCES Lillian SHANK</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>Aug 20 1986</b>		2b. HOUR <b>7:43 AM</b>	
3. SEX <b>female</b>		4. RACE <b>white</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>7 22 02</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>84</b>
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Maryland</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>WASHINGTON County MD</b>
10. CITY OR TOWN OF DEATH <b>HAGERSTOWN</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>AVALON MANOR</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>housewife</b>

13a. STATE <b>Maryland</b>		13b. COUNTY <b>Washington</b>		13c. CITY OR TOWN <b>Boonsboro</b>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	13e. STREET ADDRESS / ZIP CODE <b>Route 2 21713</b>
14. FATHER'S NAME FIRST MIDDLE LAST <b>John William Bostetter</b>			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Annie F. Kershner</b>				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>no</b>		16b. SOCIAL SECURITY NO. <b>217-48-2931</b>		17. INFORMANT ADDRESS <b>Betty L. Stouffer, Mt. Lena</b>			

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Multiple Cerebro-Vascular Accident</b>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: (b) <b>Cerebral Arteriosclerosis</b>		
DUE TO, OR AS A CONSEQUENCE OF (c) <b>Arteriosclerosis, Generalized</b>		

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)  
**Renal insufficiency - Electrolyte imbalance**

19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			

22a. I certify that (I) (this hospital) attended the deceased from **10 Aug 1986** to **20 Aug 1986**, that (I) (we) last saw the deceased alive on **10 Aug 1986** and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above; (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE <b>W. N. Fender</b>		DEGREE <b>M.D.</b>		22c. DATE SIGNED <b>21 Aug 86</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>W. N. Fender</b>		22e. ADDRESS <b>138 E. Antietam St., Hagerstown MD 20640</b>			

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>burial</b>		23b. DATE <b>Aug. 22, 1986</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Broadfording Cemetery</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Hagerstown, Wash., Maryland</b>	
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24. FUNERAL DIRECTOR NAME ADDRESS <b>MINNICH FUNERAL HOME 415 E. Wilson Blvd., Hagerstown, Md. 21740</b>		25a. DATE REC'D. BY REGISTRAR <b>AUG 26 1986</b>		25b. REGISTRAR'S SIGNATURE <b>Julia Davidson-Randall</b>	
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DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

CHILIAN RIVER

COLORED FIBER

*[Faint, mostly illegible handwritten text, possibly bleed-through from the reverse side of the page.]*

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner will be notified for an autopsy.

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										REG. NO. 6 24097	
1. FOR STATE REGISTRAR											
1. DECEASED NAME (TYPE OR PRINT) <b>Smith CORA I. Irene Smith</b>						2a. DATE OF DEATH MONTH DAY YEAR <b>8-4-86</b>		2b. HOUR <b>1:45 P.M.</b>			
3. SEX <b>female</b>		4. RACE <b>white</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>Feb. 25, 1905</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>81</b> YRS		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Maryland</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Washington</b> MD.					
10. CITY OR TOWN OF DEATH <b>Hagerstown</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Avalon Manor</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>housewife</b>		12b. KIND OF BUSINESS OR INDUSTRY			
13a. STATE <b>Maryland</b>		13b. COUNTY <b>Washington</b>		13c. CITY OR TOWN <b>Hagerstown</b>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE <b>Route 9, Box 114 21740</b>			
14. FATHER'S NAME FIRST MIDDLE LAST <b>John Elmer Waltz</b>				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Ida S. Detrow</b>							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>no</b>		16b. SOCIAL SECURITY NO. <b>705-10-5715</b>		17. INFORMANT ADDRESS <b>Chester Smith, Hagerstown, Md.</b>							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH CAUSED BY: IMMEDIATE CAUSE (a) <b>Cardiac Arrest</b>										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>Minutes</b>	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: (b) <b>Coronary Artery Disease - Melastole Ca of Breast</b> DUE TO, OR AS A CONSEQUENCE OF (c)											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <b>Congestive Failure (compensated)</b>											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE							
22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE <b>W. W. Loh</b>				DEGREE <b>MD</b>				ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED	
22d. PHYSICIAN'S NAME (TYPE OR PRINT)				22e. ADDRESS							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>burial</b>		23b. DATE <b>Aug. 7, 1986</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Rest Haven Cemetery</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Hagerstown, Wash., Maryland</b>					
24. FUNERAL DIRECTOR NAME <b>MINNICH FUNERAL HOME</b>				24b. ADDRESS <b>415 E. Wilson Blvd., Hagerstown, Md. 21740</b>		25a. DATE REC'D. BY REGISTRAR <b>AUG 7 1986</b>		25b. REGISTRAR'S SIGNATURE <b>Julia Davidson-Rendall</b>			

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1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

6 24098

1. DECEASED NAME (TYPE OR PRINT) <i>Kate</i> <i>Reba</i> <i>Kathleen</i> <i>Snowberger</i>		2a. DATE OF DEATH MONTH DAY YEAR <i>8-30-86</i>		2b. HOUR <i>5:45 P.M.</i>	
3. SEX <i>F</i> Female	4. RACE <i>W</i> White	5. DATE OF BIRTH MONTH DAY YEAR <i>Jan. 23, 1902</i>		6. AGE (IN YEARS LAST BIRTHDAY) <i>84</i> YRS. IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <i>Maryland</i>	7b. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <i>Washington</i> MD.	
10. CITY OR TOWN OF DEATH <i>Hagerstown</i>	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <i>Washington County Hospital</i>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <i>Housewife</i>		12b. KIND OF BUSINESS OR INDUSTRY <i>Home</i>
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)					
13a. STATE <i>Maryland</i>	13b. COUNTY <i>Wash.</i>	13c. CITY OR TOWN <i>Smithsburg</i>	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	13e. STREET ADDRESS / ZIP CODE <i>Rt. 4, Box 54 21783</i>	
14. FATHER'S NAME FIRST MIDDLE LAST <i>John L. Herbst</i>		15. MOTHER'S MAIDEN NAME FIRST MIDDLE <i>Lydia A. Pryor</i>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) <i>no -</i>		16b. SOCIAL SECURITY NO. <i>214-03-0976B</i>		17. INFORMANT ADDRESS <i>Mr. H. Edgar Snowberger, Smithsburg, Md.</i>	
18. CAUSE OF DEATH (Enter only one cause per line for multiple conditions) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Coronary Pulmonary Atherosclerosis</i> DUE TO, OR AS A CONSEQUENCE OF (b) <i>Arteriosclerosis</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO, OR AS A CONSEQUENCE OF (c) <i>Coronary Arteriosclerosis</i> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <i>P.M. 19</i>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from <i>8-30-86</i> , 19____, to <i>8-30-86</i> , 19____, that (I) (we) lost saw the deceased alive on <i>8-30-86</i> , 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE <i>[Signature]</i>		DEGREE		22c. DATE SIGNED <i>8-31-86</i>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <i>E. E. Lindigold</i>		22e. ADDRESS <i>307 1/2 W. Main St. Hagerstown, Md.</i>			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>Burial</i>		23b. DATE <i>Sept. 3, 1986</i>		23c. NAME OF CEMETERY OR CREMATORY <i>Smithsburg Cemetery</i>	
23d. LOCATION <i>Smithsburg, Wash., Md.</i>		23e. STATE			
24. FUNERAL DIRECTOR NAME <i>Dennis &amp; Sons</i> ADDRESS <i>Davis Funeral Home, Smithsburg, Md., 21783</i>		25a. DATE REC'D. BY REGISTRAR <i>SEP 5 1986</i>		25b. REGISTRAR'S SIGNATURE <i>[Signature]</i>	

MEDICAL CERTIFICATION

19

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 12 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with 12 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or, item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

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00-14753

1- FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

24099

1. DECEASED NAME (TYPE OR PRINT) Richard Kauffman STENGER			2a. DATE OF DEATH MONTH DAY YEAR August 6, 1986			2b. HOUR 2:26 A M				
3. SEX male		4. RACE white		5. DATE OF BIRTH MONTH DAY YEAR September 26, 1929		6. AGE (IN YEARS LAST BIRTHDAY) 56 YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Pennsylvania		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Washington MD.				
10. CITY OR TOWN OF DEATH Hagerstown		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Washington County Hospital				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) tax accountant		12b. KIND OF BUSINESS OR INDUSTRY P.E. Co.		
13a. STATE Maryland			13b. COUNTY Washington		13c. CITY OR TOWN Hagerstown		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 2203 Virginia Avenue 21740	
14. FATHER'S NAME FIRST MIDDLE LAST Albert Stenger			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Mary Kauffman							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) yes			16b. SOCIAL SECURITY NO. 162-22-7044		17. INFORMANT ADDRESS Phyllis A. Stenger, Hagerstown, Md.					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) OAT CELL CARCINOMA OF RIGHT MAIN STEM BRONCHUS DUE TO, OR AS A CONSEQUENCE OF WITH METASTASIS OF LIVER, Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) BRAIN AND BONE DUE TO, OR AS A CONSEQUENCE OF (c)									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 10 MONTHS	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:10										
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (1) this hospital attended the deceased from MARCH 1 1986 to AUGUST 5 1986, that (1) (x) last saw the deceased alive on AUGUST 5 1986, and that in (my) (x) opinion death occurred on the date and hour and from the causes stated above, (1) (x) (did) (x) view the body after death.										
22b. SIGNATURE Edward W. Ditto, III, M.D.					DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22c. DATE SIGNED AUGUST 6, 1986		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) EDWARD W. DITTO, III, M.D.					22e. ADDRESS 217 WEST WASHINGTON STREET HAGERSTOWN, MARYLAND 21740					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) burial			23b. DATE Aug. 8, 1986		23c. NAME OF CEMETERY OR CREMATORY Cedar Lawn Mem. Park		23d. LOCATION CITY OR TOWN COUNTY STATE Hagerstown, Wash., Maryland			
24. FUNERAL DIRECTOR NAME MINNICH FUNERAL HOME 415 E. Wilson Blvd., Hagerstown, Md. 21740					25a. DATE REC'D BY REGISTRAR AUG 8 1986					

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

AT THE END OF THE ROAD, THE MAIN STREET, WITH METASTASIS OF LIVER, BRAIN AND SOLE

10-11-53

10-11-53

10-11-53

10-11-53

10-11-53

10-11-53

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. FOR  
STATE  
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <i>Mary Frances Stevenson</i>			2a. DATE OF DEATH MONTH DAY YEAR <i>08-23-86</i>			2b. HOUR MIN. SEC. <i>9:45 AM</i>					
3. SEX <i>Female</i>		4. RACE <i>1 white</i>		5. DATE OF BIRTH MONTH DAY YEAR <i>07 16 1908</i>		6. AGE (IN YEARS LAST BIRTHDAY) YRS. MONTHS DAYS <i>78</i>		7. IF UNDER 1 YEAR HOURS MIN. <i>9:45 AM</i>			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <i>West Virginia</i>		7b. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <i>Washington</i> MD.					
10. CITY OR TOWN OF DEATH <i>Hagerstown</i>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <i>Washington County Hospital</i>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <i>housewife</i>		12b. KIND OF BUSINESS OR INDUSTRY			
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)					13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>						
13a. STATE <i>Maryland</i>		13b. COUNTY <i>Washington</i>		13c. CITY OR TOWN <i>Hagerstown</i>		13e. STREET ADDRESS / ZIP CODE <i>415 Carrollton Avenue 21740</i>					
14. FATHER'S NAME FIRST MIDDLE LAST <i>Albert Nicholson</i>					15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <i>Annie Davis</i>						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <i>no</i>			16b. SOCIAL SECURITY NO. <i>233-46-9261</i>		17. INFORMANT ADDRESS <i>Mr. James A. Stevenson, Hagerstown, MD.</i>						
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>white congestive heart failure</i> DUE TO, OR AS A CONSEQUENCE OF (b) <i>arteriosclerotic heart disease</i> DUE TO, OR AS A CONSEQUENCE OF (c) <i>arteriosclerotic heart disease</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>24 hrs</i> <i>4 yrs</i>			
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <i>Asystole + Klebsiella pneumonia</i>											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <i>P.M. 19</i>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)							
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE							
22a. I certify that (I) (this hospital) attended the deceased from <i>Jan 19 86</i> to <i>August 19 86</i> , that (I) (we) lost saw the deceased alive on <i>August 23 19 86</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE <i>Harold R. Titch Jr</i>					DEGREE <i>MD</i>		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED <i>8-23-86</i>		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <i>HAROLD R. Titch Jr</i>					22e. ADDRESS <i>HAGERSTOWN Md 21740</i>						
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>burial</i>		23b. DATE <i>Aug. 26, 1986</i>		23c. NAME OF CEMETERY OR CREMATORY <i>Rose Hill Cemetery</i>		23d. LOCATION CITY OR TOWN COUNTY STATE <i>Hagerstown, Wash., Maryland</i>					
24. FUNERAL DIRECTOR NAME ADDRESS <i>MINNICH FUNERAL HOME 415 E. Wilson Blvd., Hagerstown, Maryland 21740</i>					25a. DATE REC'D. BY REGISTRAR <i>AUG 27 1986</i>					25b. REGISTRAR'S SIGNATURE <i>John Davidson</i>	

BP

0-15821

100% COTTON FIBER

05-15997

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

FOR  
1. STATE  
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) <b>MARY Rosalie STOUTER</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>Aug 17 86</b>			2b. HOUR <b>3:30</b> M			
3. SEX <b>female</b>		4. RACE <b>white</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>April 1, 1923</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>63</b> YRS.		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Maryland</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Washington</b> MD.			
10. CITY OR TOWN OF DEATH <b>Hagerstown</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Washington County Hospital</b>			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>housewife</b>		12b. KIND OF BUSINESS OR INDUSTRY		
13a. STATE <b>Maryland</b>				13b. COUNTY <b>Washington</b>		13c. CITY OR TOWN <b>Hagerstown</b>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>George H. Domer, Sr.</b>				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Hazel Garlock</b>				13e. STREET ADDRESS / ZIP CODE <b>2377 Pennsylvania Avenue 21740</b>	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>no</b>			16b. SOCIAL SECURITY NO. <b>220-18-0853</b>		17. INFORMANT ADDRESS <b>Mr. Simon T. Stouffer, Hagerstown, Maryland</b>				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>myocardial infarction</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>atherosclerotic lesion</b> DUE TO, OR AS A CONSEQUENCE OF (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>days</b> <b>hrs</b>									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <b>DM II &amp; III</b>									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. <b>19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) last saw the deceased alive on <b>8/16</b> , 19 <b>86</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE <b>H. N. Weeks</b>				DEGREE <b>MD</b>		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED <b>8/17/86</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>H. N. Weeks</b>				22e. ADDRESS <b>580 Northern Avenue Hagerstown, Maryland 21740</b>					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>burial</b>		23b. DATE <b>Aug. 20, 1986</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Rest Haven Cemetery</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Hagerstown, Wash., Maryland</b>			
24. FUNERAL DIRECTOR NAME ADDRESS <b>MINNICH FUNERAL HOME 415 East Wilson Blvd., Hagerstown, Maryland 21740</b>				25a. DATE REC'D. BY REGISTRAR <b>19 9/1986</b>		25b. REGISTRAR'S SIGNATURE <b>Julia T. ...</b>			

MEDICAL CERTIFICATION

IMPORTANT: If item 21 is marked on item 18, show any injury, or other traumatic event, the medical examination must be notified to the

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

BP

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COTTON FIBER



Items, # 2a, & 21b, G-620, by STATE OF MARYLAND  
 DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

24102  
 REG. NO.

1. DECEASED NAME (TYPE OR PRINT)			2a. DATE KNOWN OF DEATH			2b. HOUR		
Dennis Wayne Symons			8-11 1986			M		
3. SEX	4. RACE	5. DATE OF BIRTH	6. AGE (IN YEARS)	7. IF UNDER 1 YR.	8. IF UNDER 24 HRS.	2c. DATE PRONOUNCED DEAD		
Male	White	June 2, 1947	39	MONTHS	DAYS	8-21 1986		
9. BIRTHPLACE (STATE OR FOREIGN COUNTRY)			7b. CITIZEN OF WHAT COUNTRY?			9. BALTIMORE CITY OR COUNTY OF DEATH		
Maryland			U.S.A.			Washington County, MD.		
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		
Hagerstown			1010 Bricker Dr., Apt. 201			Teacher		
13a. STATE			13b. COUNTY			13c. CITY OR TOWN		
Maryland			Washington			Hagerstown		
13d. INSIDE CITY LIMITS?			13e. STREET ADDRESS			21740		
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			1010 Bricker Drive					
14. FATHER'S NAME			15. MOTHER'S MAIDEN NAME			16. SOCIAL SECURITY NO.		
Alvin W. Symons			Gladys L. Spigler			214-48-2703		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES?			17. INFORMANT			424 Indiana Avenue		
No			Alvin W. Symons			Hagerstown, Md.		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART I DEATH WAS CAUSED BY:								
IMMEDIATE CAUSE (a) Gunshot Wound of Head (unspecified)								
DUE TO, OR AS A CONSEQUENCE OF								
Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.								
(b) DUE TO, OR AS A CONSEQUENCE OF								
(c)								
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).								
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY?	
							YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH			21b. TIME OF INJURY est. HOUR A.M. MONTH DAY YEAR		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)			
			? P.M. 8-11 1986		subject shot			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION			
			Home		1010 Bricker Dr., Apt. 201, Hagerstown, Washington Co., Md.			
22a. I certify that I took charge of the remains described above, held on death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input checked="" type="checkbox"/> Undetermined manner <input type="checkbox"/>								
ACTUAL SIGNATURE			TITLE (SPECIFY)			DATE SIGNED		
<i>Dennis F. Smyth</i>			Assistant			8-22-86		
EXAMINER'S NAME (TYPE OR PRINT)			ADDRESS					
Dennis F. Smyth, M.D.			111 Penn St., Balto., Md. 21201					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)			23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION	
Cremation			8-23-86		Smithsburg Crematorium		Smithsburg, Wash., Md.	
24. FUNERAL DIRECTOR			25a. DATE REC'D. BY REGISTRAR					
NAME ADDRESS			25b. REGISTRAR'S SIGNATURE					
A.K. Coffman Funeral Home, Inc.			AUG 26 1986 <i>Julia Davidson</i>					

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF, MEDICAL EXAMINER, ALONG WITH FORM-PW 3, CERTAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 2 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

15-1

Miss June 2, 1941 32

U.S.A.

Washington

Teacher

School Board

11700

1015 Fulton Drive

Washington, D.C.

Washington

434 Indiana Avenue

D. C.

Clarks

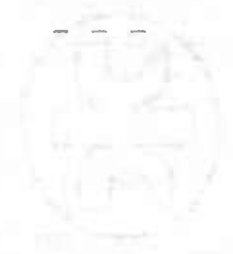
Synona

11700

434 Indiana Avenue, N.W.

204-1-3703

11700



U.S. DEPT. OF JUSTICE  
FEDERAL BUREAU OF INVESTIGATION  
WASHINGTON, D.C.

Washington, D.C. 20535

U.S. DEPT. OF JUSTICE  
FEDERAL BUREAU OF INVESTIGATION  
WASHINGTON, D.C.

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

DHMH - 16 60M 7/84  
(VRA 15, 4)

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

6 6 2 4 1 0 3

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) <b>EDGAR LEON THOMAS</b>				2a. DATE OF DEATH MONTH DAY YEAR <b>August 4, 1986</b>				2b. HOUR <b>2:30 A.M.</b>	
1. SEX <b>Male</b>		4. RACE <b>White</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>Jan. 24, 1907</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>79</b>		7. IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Maryland</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>WASHINGTON</b> MD.			
10. CITY OR TOWN OF DEATH <b>HAGERSTOWN</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>AVALON MANOR</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Laborer</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>Concrete Contractor</b>	
13a. STATE <b>Maryland</b>		13b. COUNTY <b>Washington</b>		13c. CITY OR TOWN <b>Hagerstown</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE <b>7 East Washington Street 21740</b>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>Charles W. Thomas</b>				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Annie E. Betts</b>					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>No</b>		16b. SOCIAL SECURITY NO. <b>220-10-3334</b>		17. INFORMANT ADDRESS <b>Frances L. Thomas Hagerstown, Md. 245 E. Howard Street</b>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Congestive Heart Failure</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>Arteriosclerotic Cardio-Vascular Disease</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>Chronic Obstructive Pulmonary Disease / Resp. insufficiency</b>									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <b>Chronic Obstructive Pulmonary Disease / Resp. insufficiency</b>									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) last saw the deceased alive on _____, 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did not) view the body after death.									
22b. SIGNATURE <b>W.N. Funder</b>				DEGREE <b>MD</b>				22c. DATE SIGNED <b>4 Aug 1986</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>W.N. Funder</b>				22e. ADDRESS <b>130 E. Antietam St.</b>					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>8-6-86</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Rest Haven Cemetery</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Hagerstown, Washington, MD</b>			
24. FUNERAL DIRECTOR NAME <b>A.K. Coffman Funeral Home, Inc.</b>				24b. ADDRESS <b>Hagerstown, Md.</b>		25a. DATE REC'D. BY REGISTRAR <b>AUG 11 1986</b>		25b. REGISTRAR'S SIGNATURE <b>Jane Davidson</b>	

BP \_\_\_\_\_

LEON THOMAS

Jan. 23, 1907

White

U.S.A.

Contractor

Contractor

1910

7 East Washington Street

Washington

Better

Amie

Thomas

Charles

345 E. Howard Street

25-27-29 Thomas

10

G.T. Collins Funeral Home, Inc.

Baltimore, Md.

West Haven Cemetery, West Haven, Conn.

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 1B, ON PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM MM-3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP

DHMH - 17  
(VR A15 ME (5))  
20M 4/82

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

24104

1- FOR STATE REGISTRAR		2a. DATE KNOWN OF DEATH		2b. HOUR	
1. DECEASED NAME (TYPE OR PRINT)		2c. DATE ESTIMATED		2d. HOUR	
Steve Uzela		8 20 1986		9 40 PM	
3. SEX	4. RACE	5. DATE OF BIRTH	6. AGE (IN YEARS)	IF UNDER 1 YR.	IF UNDER 24 HRS.
Male	White	3-27-1896	90 YRS.	MONTHS	DAYS
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED	NEVER MARRIED	9. BALTIMORE CITY OR COUNTY OF DEATH	
Yugoslavia	U.S.A.	WIDOWED	DIVORCED	Washington MD.	
10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION	12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			
Hagerstown	Western Maryland Center	Repairman Marquett Cement			
13a. STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS?	13e. STREET ADDRESS	
Maryland	Washington	Hagerstown	YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	817 Security Road 21740	
14. FATHER'S NAME	15. MOTHER'S MAIDEN NAME	16. SOCIAL SECURITY NO.			
George Uzela	Mildred Unknown	213-10-6806			
17. WAS DECEASED EVER IN U.S. ARMED FORCES?	18. INFORMANT	ADDRESS			
No	Mamie E. Uzela	same as 13			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART I DEATH WAS CAUSED BY:					
9289 IMMEDIATE CAUSE (a) Sepsis 038					
DUE TO, OR AS A CONSEQUENCE OF					
Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.					
(b) Urinary tract infection 599					
DUE TO, OR AS A CONSEQUENCE OF					
(c)					
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).					
Compressive fracture lumbar spine, Subdural hematoma, Dementia, Renal failure, Hypertension					
19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY?
					YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH	21b. TIME OF INJURY	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)			
	HOUR A.M. MONTH DAY YEAR				
	P.M. 19				
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)	21f. LOCATION			
		CITY OR TOWN COUNTY STATE			
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> .					
ACTUAL SIGNATURE	TITLE (SPECIFY)				DATE SIGNED
	M.D. Dept. Assist. MEDICAL EXAMINER				8/21/86
EXAMINER'S NAME (TYPE OR PRINT)	ADDRESS				
	1610 Oak Hill Ave Hagerstown MD				
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION	COUNTY	STATE
Burial	8-23-86	Rest Haven Cemetery	Hagerstown	Wash.	Md.
24. FUNERAL DIRECTOR NAME	25a. DATE REC'D. BY REGISTRAR				25b. REGISTRAR'S SIGNATURE
Gerald N. Minnich	Hagerstown, Maryland				

1221-

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00-81788

1. FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

86 24105

1. DECEASED NAME (TYPE OR PRINT) FIRST: Jean MIDDLE: Ann LAST: Weaver			2a. DATE OF DEATH MONTH: 8 DAY: 20 YEAR: 86		2b. HOUR 8:17 PM			
3. SEX female		4. RACE white		5. DATE OF BIRTH MONTH: January DAY: 2 YEAR: 1933		6. AGE (IN YEARS LAST BIRTHDAY) 53 YRS.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) New York City		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Washington MD		
10. CITY OR TOWN OF DEATH Hagerstown		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Washington County Hospital			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) housewife		12b. KIND OF BUSINESS OR INDUSTRY	
13a. STATE Maryland				13b. COUNTY Washington		13c. CITY OR TOWN Hagerstown		
13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>				13e. STREET ADDRESS / ZIP CODE 405 Ridge Avenue 21740				
14. FATHER'S NAME FIRST: William MIDDLE: LAST: O'Rourke			15. MOTHER'S MAIDEN NAME FIRST: Helen MIDDLE: LAST: Sweeney					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) no			16b. SOCIAL SECURITY NO. 097-24-4557		17. INFORMANT ADDRESS Jim H. Weaver, Hagerstown, Md.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) cardiorespiratory arrest DUE TO, OR AS A CONSEQUENCE OF (b) diffuse intra-abdominal carcinomatous DUE TO, OR AS A CONSEQUENCE OF (c) probable pancreatic cancer - primary APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 5 minutes 6 months								
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)								
19a. DATE OF OPERATION 8/15/86 8/18/86		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED renal failure		20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)				
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE				
22a. I certify that (I) (this hospital) attended the deceased from 8/12, 19 86 to 8/20, 19 86, that (I) (we) last saw the deceased alive on 8/20, 19 86, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (d) (d) (did not) view the body after death.								
22b. SIGNATURE Stephen M. Sachs				DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 8/21/86		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) STEPHEN M. SACHS				22e. ADDRESS 239 N. Potomac St.				
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) cremation		23b. DATE Aug. 21, 1986		23c. NAME OF CEMETERY OR CREMATORY Smithsburg Crematory		23d. LOCATION (CITY OR TOWN) COUNTY STATE Smithsburg, Wash., Maryland		
24. FUNERAL DIRECTOR NAME: MINNICH FUNERAL HOME ADDRESS: 415 E. Wilson Blvd., Hagerstown, Md. 21740				25a. DATE REC'D. BY REGISTRAR AUG 26 1986				
				25b. REGISTRAR'S SIGNATURE John Davidson-Randall				

MEDICAL CERTIFICATION

1  
2

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP





00-81794

1- FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) <b>John W Whittington</b>		2a. DATE OF DEATH MONTH DAY YEAR <b>8-22-86</b>		2b. HOUR <b>5 A M</b>	
3. SEX <b>Male</b>		4. RACE <b>White</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>5 25 08</b>	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>West Virginia</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>78</b> YRS.	
10. CITY OR TOWN OF DEATH <b>Hagerstown</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Washington County Hospital</b>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Washington</b> MD.	
12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>railroad</b>		12b. KIND OF BUSINESS OR INDUSTRY			
13a. STATE <b>Maryland</b>		13b. COUNTY <b>Washington</b>		13c. CITY OR TOWN <b>Hagerstown</b>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>James Easton</b>		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Nellie</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) <b>no</b>		16b. SOCIAL SECURITY NO. <b>216-03-3505</b>		17. INFORMANT ADDRESS <b>James B. Whittington, Frederick, Md.</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>CARDIORESPIRATORY ARREST</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>BRONCHOGENIC CARCINOMA</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>RADIATION PNEUMONITIS</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>	
21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)		21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> WHILE <input type="checkbox"/> AT HOME		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	
21f. LOCATION STREET CITY OR TOWN COUNTY STATE		22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last saw the deceased alive on above; (I) (we) did/did not view the body after death.			
22b. SIGNATURE <b>[Signature]</b>		DEGREE <b>MD</b>		22c. DATE SIGNED <b>8/22/86</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT)		22e. ADDRESS			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>burial</b>		23b. DATE <b>Aug. 25, 1986</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Rest Haven Cemetery</b>	
23d. LOCATION CITY OR TOWN COUNTY STATE <b>Hagerstown, Wash., Maryland</b>		24. FUNERAL DIRECTOR NAME ADDRESS <b>MINNICH FUNERAL HOME 415 E. Wilson Blvd., Hagerstown, Md. 21740</b>		25a. DATE REC'D. BY REGISTRAR <b>Aug 27 1986</b>	
25b. REGISTRAR'S SIGNATURE <b>[Signature]</b>					

MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP \_\_\_\_\_

*[Faint, illegible handwritten text, possibly bleed-through from the reverse side of the page]*

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00-81768

Item # 16b, Film G 622,12/1/86 ra

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 6 2 4 1 0 7  
REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <del>Wilber</del> Frederick R Wilber			2a. DATE OF DEATH MONTH DAY YEAR 8 18 84		2b. HOUR M
3. SEX male	4. RACE white	5. DATE OF BIRTH MONTH DAY YEAR November 4, 1930		6. AGE (IN YEARS LAST BIRTHDAY) 55	IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Rhode Island	7b. CITIZEN OF WHAT COUNTRY? USA	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Washington MD.	
10. CITY OR TOWN OF DEATH Hagerstown	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Washington County Hospital		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) co-owner		12b. KIND OF BUSINESS OR INDUSTRY Technical Eng.
13a. STATE Maryland			13b. COUNTY Washington	13c. CITY OR TOWN Hagerstown	
14. FATHER'S NAME FIRST MIDDLE LAST Fred R. Wilber			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Laura I. Keck		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) Yes		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 1950-1952 039-18-7625		17. INFORMANT ADDRESS P. Marie Wilber, Hagerstown, Md.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Diffuse Metastatic Disease</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Calculation of Kidney</u> DUE TO, OR AS A CONSEQUENCE OF (c) _____					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>5 mo</u> <u>6 mo</u>
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <u>Paraplegia due to spinal (T1-T2) metastasis</u>					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1B, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from 8/12/84 to 8/18/84, that (I) <del>have</del> last saw the deceased alive on 8/12/84, and that in (my) <del>own</del> opinion death occurred on the date and hour and from the causes stated above; (I) <del>would</del> (did not) view the body after death.					
22b. SIGNATURE <u>Edmund Moody</u>				22c. DATE SIGNED 8/18/84	
22d. PHYSICIAN'S NAME (TYPE OR PRINT)				22e. ADDRESS	
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) burial		23b. DATE Aug. 20, 1986	23c. NAME OF CEMETERY OR CREMATORY Rest Haven Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Hagerstown, Wash., Maryland
24. FUNERAL DIRECTOR NAME ADDRESS MINNICH FUNERAL HOME 415 E. Wilson Blvd., Hagerstown, Md. 21740				25a. DATE REC'D. BY REGISTRAR 25b. REGISTRAR'S SIGNATURE AUG 26 1986 Julia Davidson-Randall	

MEDICAL CERTIFICATION

18-19-20-21-22-23-24-25

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon copiers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified or called.

BP

0-81700

00-16987

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM 400-1. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH										REG. NO. 24108					
1. DECEASED NAME (TYPE OR PRINT) <b>Ellsworth Harold Wilson</b>										2a. DATE KNOWN OF DEATH <input checked="" type="checkbox"/> MONTH DAY YEAR <b>Aug 26 1986</b>		2b. HOUR <b>8:53 M</b>			
3. SEX <b>Male</b>		4. RACE <b>White</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>Aug. 9, 1914</b>		6. AGE (IN YEARS) LAST BIRTHDAY <b>72 YRS.</b>		IF UNDER 1 YR. MONTHS DAYS HOURS MIN.		2c. DATE PRONOUNCED DEAD <b>Aug 26 1986</b>		2d. HOUR <b>8:53 M</b>			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Maryland</b>				7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>				8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>				9. BALTIMORE CITY OR COUNTY OF DEATH <b>Washington</b>		MD.	
10. CITY OR TOWN OF DEATH <b>Hagerstown</b>				11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Washington County Hospital</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Guard</b>				12b. KIND OF BUSINESS OR INDUSTRY <b>Security Serv</b>			
13a. STATE <b>Md.</b>				13b. COUNTY <b>Wash.</b>		13c. CITY OR TOWN <b>Hagerstown</b>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS <b>Rt. 2, Box 1103</b>		21740			
14. FATHER'S NAME FIRST MIDDLE LAST <b>Russell - Wilson</b>						15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Edna May Hankey</b>									
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) <b>yes</b>				16b. SOCIAL SECURITY NO. <b>WW II</b>		17. INFORMANT ADDRESS <b>Mrs. Ethel M. Wilson, Hagerstown, Md.</b>									
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Coronary occlusion</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost. (b) <b>Atherosclerotic Disease</b> DUE TO, OR AS A CONSEQUENCE OF (c)												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>3-4 hrs</b>			
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I															
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?								20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19				21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)				21f. LOCATION STREET CITY OR TOWN COUNTY STATE							
22a. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> .															
ACTUAL SIGNATURE <b>H. N. Weeks</b>				TITLE (SPECIFY) <b>Dep</b>				M.D. <b>Med</b>				DATE SIGNED <b>Aug 27 86</b>			
EXAMINER'S NAME (TYPE OR PRINT) <b>H. N. Weeks</b>				ADDRESS <b>580 Northern Ave Hagerstown Md</b>											
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Cremation</b>				23b. DATE <b>Aug. 27, 1986</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Smithsburg Crematorium</b>				23d. LOCATION CITY OR TOWN COUNTY STATE <b>Smithsburg, Wash., Md.</b>					
24. FUNERAL DIRECTOR NAME <b>Dennis R Davis</b>				25a. DATE REC'D. BY REGISTRAR <b>SEP 4 1986</b>				25b. REGISTRAR'S SIGNATURE <b>[Signature]</b>							
Davis Funeral Home, Smithsburg, Md., 21783															

BP

DHMH - 17  
(VR A15 ME (5))  
20M 4/82

00-18881

00-81786

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of the event.

1- FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

24109

1. DECEASED NAME (TYPE OR PRINT) <b>Thomas E. Wilson</b>			2a. DATE OF DEATH MONTH <b>08</b> DAY <b>19</b> YEAR <b>86</b>			2b. HOUR <b>4:32</b> A.M.											
3. SEX <b>Male</b>		4. RACE <b>1</b>		5. DATE OF BIRTH MONTH <b>03</b> DAY <b>31</b> YEAR <b>1913</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>73</b> YRS.		IF UNDER 1 YEAR MONTHS <b>00</b> DAYS <b>00</b>		IF UNDER 74 HRS HOURS <b>00</b> MIN. <b>00</b>							
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>West Virginia</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Washington</b> MD.											
10. CITY OR TOWN OF DEATH <b>Hagerstown</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Washington County Hospital</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>self-employed</b>			12b. KIND OF BUSINESS OR INDUSTRY <b>sheet metal</b>								
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)			13a. STATE <b>Maryland</b>			13b. COUNTY <b>Washington</b>			13c. CITY OR TOWN <b>Hagerstown</b>			13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			13e. STREET ADDRESS / ZIP CODE <b>1823 W. Washington St. 21740</b>		
14. FATHER'S NAME FIRST <b>Frank</b> MIDDLE <b>Wilson</b> LAST <b>Wilson</b>			15. MOTHER'S MAIDEN NAME FIRST <b>Mary</b> MIDDLE <b>King</b> LAST <b>King</b>														
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>no</b>			16b. SOCIAL SECURITY NO. (# YES, GIVE WAR OR DATES) <b>031-05-0628</b>			17. INFORMANT ADDRESS <b>Kathleen Wilson, Hagerstown, Md.</b>											
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Respiratory Failure</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Chronic Obstructive Pulmonary Disease / Cor pulmonale of long - primary unknown</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>Diabetes mellitus Arteriosclerotic Heart Disease</b>										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I																	
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>								
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. <b>19</b>			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1B PART 1 OR PART 2)											
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE											
22a. I certify that (I) (this hospital) attended the deceased from <b>1 Nov.</b> 19 <b>84</b> to <b>19 Aug</b> 19 <b>86</b> that (I) (we) lost saw the deceased alive on <b>18 Aug</b> 19 <b>86</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) show the body after death.																	
22b. SIGNATURE <b>W. N. Fender</b> MD						DEGREE <b>MD</b>			22c. DATE SIGNED <b>19 Aug 86</b>								
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>W. N. Fender</b>						22e. ADDRESS <b>138 E. Antietam St., Hagerstown Md.</b>											
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>burial</b>			23b. DATE <b>Aug. 21, 1986</b>			23c. NAME OF CEMETERY OR CREMATORY <b>Cedar Lawn Mem. Park</b>			23d. LOCATION CITY OR TOWN COUNTY STATE <b>Hagerstown, Wash., Maryland</b>								
24. FUNERAL DIRECTOR NAME <b>MINNICH FUNERAL HOME</b> ADDRESS <b>415 E. Wilson Blvd., Hagerstown, Md. 21740</b>						25a. DATE REC'D. BY REGISTRAR <b>AUG 26 1986</b>			25b. REGISTRAR'S SIGNATURE <b>Julia Davidson-Rodgers</b>								

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00-15869

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH24110  
REG. NO.

1. DECEASED NAME (TYPE OR PRINT) <b>DANIEL</b> <i>Daniel</i>		MIDDLE <b>D.</b> <i>D.</i>		LAST <b>WINES</b> <i>Wines</i>		2a. DATE OF DEATH MONTH DAY YEAR <b>7-27-86</b>		2b. HOUR <b>M</b>	
3. SEX <b>Male</b>		4. RACE <b>White</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>Feb. 14 1930</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>56</b> YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Virginia</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Washington</b> MD.			
10. CITY OR TOWN OF DEATH <b>Hagerstown</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Washington County Hospital</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>cab &amp; truck driver</b>		12b. KIND OF BUSINESS OR INDUSTRY	
13a. STATE <b>Maryland</b>		13b. COUNTY <b>Washington</b>		13c. CITY OR TOWN <b>Hagerstown</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE <b>52 East Antietam St. 21740</b>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>Elias</b>		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Pearl</b>		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) YES (Army)					
16b. SOCIAL SECURITY NO. <b>231-34-5342</b>		17. INFORMANT ADDRESS <b>Claude Hagans Rt. 5, Box 262, Winchester, Va.</b>							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Coronary heart failure</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>atherosclerotic heart disease</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (c) PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <b>Chronic obstructive pulmonary disease</b>								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>hours</b> <b>years</b>	
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> HOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (1) (this hospital) attended the deceased from <b>July 17 1986</b> to <b>July 27 1986</b> that (2) <del>the</del> <b>last</b> saw the deceased alive on <b>July 24 1986</b> and that in (my) <del>my</del> opinion death occurred on the date and hour and from the causes stated above; (3) <del>the</del> <b>did not</b> view the body after death.									
22b. SIGNATURE <i>Edson B. Moody</i>		DEGREE <b>MD</b>		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED <b>7/28/86</b>			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>Edson B. Moody</b>		22e. ADDRESS <b>College Road, Hagerstown, Maryland</b>							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Cremation</b>		23b. DATE <b>7-30-86</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Eaders Funeral Home &amp; Crematory</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Berryville Clarke Va.</b>			
24. FUNERAL DIRECTOR NAME <b>A.K. Coffman Funeral Home, Inc.</b>		Hagerstown, Md.		25a. DATE OF REGISTRATION <b>AUG 08 1986</b>		25b. REGISTRAR SIGNATURE <i>John T. ...</i>			

MEDICAL CERTIFICATION

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of this.

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